the Canadian Nurse

VOLUME 57 • NUMBER 1

MONTREAL

JANUARY 1961

Sincere Wishes
for a
Happy
and
Prosperous
New Year

OWNED AND PUBLISHED BY

THE CANADIAN NURSES' ASSOCIATION


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THE CANADIAN NURSE

VOLUME 57 **NUMBER 1**

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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Between Ourselves

The opening of a new year! Some will tell us that this is the beginning of the sixth decade of this century, others that it began a year ago. Whichever choice you make of those alternatives, we hope that it will be a happy and satisfying year for you.

* * *

In the past three issues we have shared with you the addresses that FLORENCE E. ELLIOTT gave to a small group at a workshop sponsored by the Canadian Nurses' Association. The fourth and last of this series — Philosophy and Curriculum — is published in this number. To employ a very trite expression, there is much "food for thought" in this series.

PRESIDENT HELEN CARPENTER has entitled her New Year's message "1961 — The Year of Challenge." Where else could we all start to accept this challenge more fully than by familiarizing ourselves with the intricacies of nursing education as delineated by Miss Elliott?

* * *

Proud parents await with eagerness the moment when their offspring will utter his first intelligible word — when he will communicate. A captive audience on that occasion, those same parents may completely ignore the advice of the public health nurse who has been trying to persuade the mother to bring her baby to Health Centre to begin the immunization program.

Nurses, on the whole, have hesitated to talk about their work, their professional aspirations, the need for public understanding of the efforts to improve the programs of nursing education. For years, for example, we have declared that financial support for schools of nursing should receive the same kind of governmental assistance as is given to other schools. Briefs have been prepared. Interviews with the authorities who control the public purse have been arranged. We should ask ourselves the question posed by J. A. P. CLARK — "Is anybody listening?"

Mr. Clark discusses the all-important "C's" of communication. SISTER MURIEL turns the spotlight back on *us* as she discusses one vitally important aspect of this topic — the art of listening. Are you a good listener? Now turn to Miss King's article and read about a communications program that has worked.

So many new nurses' homes have been built in the past few years that those of us who are numbered among the older graduates will have a feeling of kinship for MRS. JEAN SHERWIN. Her description of what she found in the new residence at Royal Alexandra Hospital, Edmonton could be duplicated in dozens of communities.

* * *

Last month, the sad announcement of the sudden death of Gertrude May Hall was included among the items in the In Memoriam column. We are indebted to DR. EARL P. SCARLETT, senior physician in the Calgary Clinic, for permission to share with you here the tribute which he pays to Miss Hall's outstanding service to the Calgary General Hospital.

* * *

On page 45 you will find the latest listing of the various publications that may be procured from the Canadian Nurses' Association. Many of them are free. Those for which a charge is made are offered for sale practically at cost.

Much of this material would be a most valuable aid to girls' counsellors in the high schools of your community. They often write to us here at the *Journal* office asking for the kind of information these various pamphlets and brochures can provide. A worthwhile chapter project would be to procure a sufficient quantity to supply a set to each counsellor in your area. Send your order now to the Canadian Nurses' Association, 74 Stanley Avenue, Ottawa 2, Ontario.

* * *

Although numerous poetic offerings find their way to our desk in the course of a year, the great majority of them are of the "grateful patient" variety, extolling the virtues of nurses to the limit. Perhaps we should use some, now and then, in Random Comments so that you might know how many superlatives are used to describe the care you give.

When a nurse writes a poem, we consider it much more important to find space for it, if possible. We feel it would help to start the year off in the right direction if every nurse were to repeat the brief poem composed by NADINE BARRETT. Miss Barrett is a student in the school of nursing of Women's College Hospital, Toronto.

Pharmaceuticals

and other products

ACTIFED TABLETS AND SYRUP (BURROUGHS WELLCOME)

Indications—For the prophylaxis and treatment of allergic conditions in which antihistamines have been found useful, especially: hay fever, allergic rhinitis, vasomotor rhinitis, allergic asthma and for symptoms associated with the common cold. Also for prophylaxis and treatment of eustachian tube congestion, aero-otitis media, croup and sinusitis.

Description—A combination of Actidil (tripolidine HCl) a high potency antihistamine and Sudafed (pseudoephedrine HCl) a nasal decongestant. Each tablet contains Actidil 2.5 mg. and Sudafed 60 mg. Each 5 cc. tsp. contains Actidil 1.25 mg. and Sudafed 30 mg.

Administration—Adults and children over 6 yrs.: 2 tsp. or 1 tablet t.i.d. Children 4 mos. to 6 yrs.: 1 tsp. or ½ tablet t.i.d. Infants up to 3 mos.: ½ tsp. t.i.d.

AKALON-T (STRASENBURGH)

Indications—For relief of pain, preprandial distress and other symptoms of peptic ulcer.

Description—A potent, long-acting (8-12 hours) anticholinergic. Each Akalon-T "5" capsule contains methscopolamine 5 mg. and Tuazole 20 mg. Each Akalon-T "10" capsule contains methscopolamine 10 mg. and Tuazole 40 mg.

Administration—Usual effective dose: 1 capsule q.12 h.

BROCSIL (BEECHAM)

Indications—For treatment of infections caused by penicillin-sensitive organisms.

Description—Each tablet contains potassium penicillin. A synthetic penicillin derived from the penicillin "nucleus" 6-amino penicillanic acid.

Administration—Orally: 125 mg. or 250 mg. t.i.d. according to the severity of the infection.

DANABOL$^{T.M.}$ (CIBA)

Indications—Debilitated states; pre- and postoperative conditions, burns, decubitus ulcers and accidental trauma, osteoporosis and postmenopausal low back pain; prevention and treatment of corticosteroid catabolism.

Contraindications—Prostatic carcinoma or severe liver damage. Use with caution when liver impairment is suspected.

Description—Danabol (méthandrostenolone) is a potent, anabolic agent.

Administration—Average adult dose: 1-2 tablets q.d. In severe states 2-4 tablets. Intermittent therapy is indicated if administered over long periods.

FURACIN-H.C. CREAM (AUSTIN)

Indications—For topical application in infected and potentially infected dermatoses, pyodermas, ulcers, burns and after plastic, anorectal and minor surgery.

Description—Water-soluble topical antibacterial in a vanishing cream base. Combination of nitrofurazone and hydrocortisone.

Administration—Apply in uniform thin coating q.d. Dressing may be used.

HEMOCOAVIT (WYNLIT)

Indications—Hypoprothrombinemia and capillary disorders.

Description—Each tablet contains: Vitamin C 50 mg., hesperidine methylchalcone 25 mg., rutin 25 mg., esculine 2 mg. and Vitamin K 5 mg. Each 10 cc. vial of injectable Hemocoavit contains: Vitamin C 300 mg., hesperidine methylchalcone 100 mg., rutin 100 mg., esculine 15 mg., Vitamin K 15 mg.

Administration—Tablets: 4-8 daily. Injectable: 1 vial daily in desired solution by subcutaneous, intramuscular or intravenous injections.

LIDOSPORIN (BURROUGHS WELLCOME)

Indications—Treatment of infection, pain and itching associated with otitis externa, including swimmer's ear.

Description—Each cc. contains: Aerosporin (polymyxin B sulfate) 10,000 units, Xylocaine HCl (lidocaine hydrochloride) 50 mg., propylene glycol q.s.

Application—After preliminary cleansing and drying, instil 3 or 4 drops into infected ear 3-4 times daily. A wick may be left in canal for 24-48 hrs., and kept moistened p.r.n.

STAPHCILLIN (BRISTOL)

Indications—Treatment of staphylococcal infections due to resistant organisms.

Description—Synthetic parenteral penicillin. Each dry filled vial contains 1 Gm. Staphcillin (dimethoxyphenyl penicillin sodium).

Precautions—Caution should be observed in patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin.

Administration—I/M Adults: 1Gm. q. 4-6 h. Infants and children: 25 mg. per Kg. of body weight q.6h. I/V:1Gm. q.6h. using 50 ml. of sterile saline at 10 ml. per minute.

The Journal *presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

TACARYL (MEAD JOHNSON)

Indications—In the management of nasal allergies, allergic conjunctivitis, bronchitis, asthma, urticaria and angioneurotic edema. For the relief of itching in a variety of dermatoses.

Description—Each tablet contains 8 mg. of methdilazine hydrochloride (a synthetic derivative of phenothiazine). Each 5 cc. teaspoonful of syrup contains 4 mg.

Precautions—To be used with caution in patients receiving alcohol, analgesics or sedatives, particularly barbiturates.

Administration—Adults: 1 tablet or 2 tsp. of syrup b.i.d. increasing to t.i.d. or q.i.d. Children: One half the adult dose.

VESPRIN EMULSION (SQUIBB)

Indications—Anxiety, tension, psychoses, nausea and vomiting, and the alcohol withdrawal syndrome.

Description—Vanilla-flavored vegetable oil emulsion. Each cc. contains 10 mg. of trifluprомazine hydrochloride.

Administration—Oral, on an individualized basis.

Random Comments

Dear Editor:

I enjoy reading the *Journal* very much and especially Dr. E. M. Watson's article "Clinical Laboratory Procedures." I'm sure all nurses will find it most helpful as a reference for normal values. I know I will.

BERTHE BEAMISH, Alberta

Dear Editor:

I find the *Journal* very interesting. I wonder if it would be possible to have a question and answer section similar to those I have seen in other journals.

BERTHE HERON, Quebec

¶We will be pleased to publish subscribers' questions and answers in this column. Ed.

Dear Editor:

I would like to take this opportunity to tell you how much I enjoy *The Canadian Nurse.* At present I am inactive so the magazine helps me to keep in touch with our profession.

F. R. VANCE, Saskatchewan

Dear Editor:

I enjoy and derive much benefit from our interesting and informative magazine.

MRS. MINNIE ROSENBERGER, Alberta

Dear Editor:

I would like to take this opportunity to express my appreciation for the informative, up-to-date magazine each month, particularly now that I am no longer actively nursing.

B. M. DUNGAN, British Columbia

PRAYER OF A STUDENT NURSE

NADINE BARRETT

We seek to please Thee in our toil,
To strengthen body, heart, and mind,
Hear, Oh Lord, our cry for courage,
To seek Thy Wisdom and to find.

Grant us patience, strength unfailing,
When hearts are weary and souls are weak,
To search above these times of trial,
Thy holy face of calm to seek.

Grant love, and grace, undoubting faith,
To ease a while their troubled pain,
And grant, Oh Lord, with joyful heart,
The will to give and give again.

...christening coming up!

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 57 NUMBER 1

MONTREAL, JANUARY 1961

1961
A YEAR OF CHALLENGE

THE THEME OF THIS BIENNIUM was taken from a discussion of Ideals, Aims and Principles of Education, the introductory chapter in a book entitled *Education in Great Britain*, by W. O. Lester Smith. Smith speaks of Matthew Arnold, a "zealous inspector of schools as well as a distinguished man of letters" whose favorite quotation was "semper aliquid certi proponendum est . . . always some certain end must be kept in view." Now, the particular end which the good teacher . . . keeps always in view, says Smith, is "the product of his labors."

The phrase "always some certain end must be kept in view" was chosen as the theme in the hope that it would serve as an inspiration and guide in this important period in the work of our Association. Canadian nurses are concerned about the quality of education for nursing in many of our schools and the quality of nursing service that we are able to give the people of Canada. In the majority of schools, students are associated with the nursing service of the hospital from the beginning of their educational experience. Many hospitals are finding it difficult to obtain and hold graduate nurses and to maintain a high standard of service. They are forced to rely on students to supplement the service of graduate staff and auxiliary

(Ballard & Jarrett)

HELEN M. CARPENTER

personnel. Throughout their training period students are expected to apply the teaching that they have received under conditions that would make it hard for the most mature, experienced nurse to carry out her responsibilities.

Nurses across the country are concerned about the problems which are illustrated so clearly in *Spotlight on Nursing Education,* the Report of the Pilot Project on Evaluation of Schools of Nursing. The concern of the profession regarding the quality of nursing education and nursing service in Canada is expressed in the recommendations of the Pilot Project. The implementation of three of the recommendations is the major task before the Association this biennium.

> 1. That a re-examination and study of the whole field of nursing education be undertaken;
>
> 2. that a school improvement program be initiated to assist schools in upgrading their educational programs;
>
> 3. that a program be established for evaluating the quality of nursing service in the areas where students in schools of nursing receive their clinical experience.

It was further recommended that the Canadian Nurses' Association should initiate the study of the whole field of nursing and that representatives of nursing, of general education, of service agencies such as hospitals, public health agencies and hospital commissions, and other appropriate groups should be involved in this study. Miss Helen K. Mussallem, director of the Pilot Project was appointed to initiate, coordinate and direct the activities involved in this study, as well as those associated with the implementation of the other two Recommendations.

All nurses will recognize that if we are to succeed in this undertaking, we will need the whole-hearted support of every member of our Association. Studies directed at self-examination and evaluation tend to arouse fear and a sense of insecurity. It is often difficult to be objective and frank in revealing problems and to support those whose responsibility it is to guide the profession in the evaluation of these problems.

In her address at the 1960 biennial meeting, Miss Mussallem quoted from a discussion of problems of general education by Dr. George Flower, who said:

> As a people we are willing to move — we *are* moving — educationally, but we do not move together. The action of one often offsets the action of another, and none of us seems entirely satisfied with the results. The big problem is, how can all this interest and drive and concern and conviction be harnessed, be coordinated, be channelled, the better to serve us as individuals and as a nation.

At the same meeting, Reverend H. St. C. Hilchey, rector of St. Paul's Church, Halifax, in reviewing the historical development of nursing, said:

> . . . yours is a great tradition; a tradition of determination and courage, of battling against prejudice and inefficiency, of holding on to a dream until that dream becomes a reality.

As we enter upon this New Year, a year in which the work of our Association is more important than ever before in our history, let us be clear concerning the end we have in view for nursing. Let us channel our efforts and make a coordinated attack on our problems. Let us search for and define the values fundamental to the development of strong schools of nursing and higher standards of nursing service. Let us accept responsibility for "hard thinking" about the problems that beset our profession. Let us participate in and encourage lively, interested and fruitful discussion concerning these problems.

HELEN M. CARPENTER
President
Canadian Nurses' Association

It takes

2.58 lbs. of milk to fill 1 qt. of fluid milk

23.4 lbs. of milk to make 1 lb. of creamery butter

11 lbs. of milk to make 1 lb. of cheese

17 lbs. of milk to make 1 gal. of ice cream

2.3 lbs. of milk to make 1 lb. of evaporated milk

8 lbs. of milk to make 1 lb. of whole powdered milk

FUNDAMENTALS OF COMMUNICATION

JOSEPH A. P. CLARK

This is the text of a lecture prepared for the course in Public Relations at the University of Toronto.

ALL OF THE DICTIONARY definitions make it clear that communication requires a *communicator,* a *message,* and an *audience,* and that no communication takes place unless the audience *receives* the message sent by the communicator.

All of this will seem pretty elementary. It *is* elementary but, surprisingly enough, it is all too often overlooked by those of us engaged in the practice of public relations. We are easily trapped into a preoccupation with the techniques — techniques in publicity, methods of distribution, employment of printed materials of all kinds, and so on. These are complex, ever-changing and constantly presenting new challenges to our skill, intelligence and imagination.

But we never should forget that *unless our messages are received* by those people to whom we wish to communicate, all of our techniques, all of our carefully worked out programs are doomed to failure. A few years ago *Fortune,* in an examination of modern public relations, headed its article: "Is Anybody Listening?" This article caused a lot of soul-searching among those responsible for some of the largest public relations organizations in American industry.

Let us, then, mark firmly in our minds that the all-important fundamental in communication is that our messages be received. Of course, for this to happen is not a simple matter. Scott Cutlip, associate professor of journalism at the University of Wisconsin, has selected what he calls the "Seven C's of Communication" which gives us a handy check list in considering the various aspects of this subject. Let me say now that while I use Professor Cutlip's C's he cannot be held responsible for my exposition of them; I have borrowed freely, not only from my own experience, but also from a wide variety of useful papers and texts.

Mr. Clark is President, Tisdall, Clark and Lesly Ltd., 20 Carlton Street, Toronto.

The Seven C's

1. *Credibility*

Your audience must be prepared to believe what you say. Emerson said, "What you are shouts so loud I cannot hear what you say." If your audience — your public — has the impression that you are not to be trusted, that your motive in communicating to them is dubious, it is extremely unlikely that your message will get through.

2. *Context*

Since, in public relations, we are usually communicating to groups of people — and since we are, therefore, usually concerned with media of mass communication — we must always be sure that those facts and ideas of your organization which people have gained from personal experience, from personal contact, are not contradicted by your message.

> To give a hypothetical and extreme example, effective communication couldn't possibly result if you were to prepare a special publication for employees of a company, designed to boost morale and create esprit de corps, if the theme was that the company was a wonderful place to work — when, in fact, the company paid starvation wages, the environment was filthy and dangerous, and they had a hard time getting anybody to work there. I said that this was an extreme example, but the important fact is that all too often public relations programs do try to communicate half-truths to publics who simply refuse to swallow them because they know better.

3. *Content*

What you communicate must have interest for the people whom you are trying to influence. But there is far

more involved than simply determining on a content to interest them. In constructing your messages you will always have a definite objective in mind. To inform — persuade — create knowledge out of ignorance — transform hostility to approval — bring interest out of apathy.

General objectives such as these invariably rule communications programs in public relations. If you are to succeed in attaining any of these objectives, you must relate the content of your messages to the people who will be receiving them. Not only must your message be clear, simple, easy to understand but it must avoid a complex host of barriers that are always present in the minds and emotions of people.

Imagine trying to stir the people of your own community into an informed interest in prevailing wage rates of Patagonian basket-weavers! You could spend a million dollars on every conceivable form of communications, but unless the wage rates of Patagonian basket-weavers could somehow be related to the lives of the people of your town, your money and your efforts would be wasted.

In general, people select, from all the messages that are rained against them those items which *promise the greatest rewards* and *appear to be significant to them.*

People have a very poor intellectual appetite, so make your messages not only appetizing but small enough to be digested. Everyone is more interested in people than things — so work people into your messages. Quote sources they admire, if you want to persuade them to accept your point of view.

Whenever possible mix an emotional ingredient into the facts and logic of your message, but be sure you know enough about your audience when you are concocting your emotional appeal. Remember to go easy on anything designed to arouse the emotion of fear.

Rarely will your audience draw the conclusions you want if you simply state your facts and arguments. As a general rule, include the conclusions with your message.

4. *Clarity*

The message must be easy to understand — it must employ words, ideas, sounds, symbols, and themes capable of quick comprehension. There is no more important study for the public relations practitioner than *semantics* — the meaning and interpretation of words and groups of words. The dictionary, Fowler's Modern English Usage, Roget's Thesaurus, The Art of Plain Talk by Rudolph Flesch, are just some of the bibles about words which should never be far from the writing hand of the communicator.

But even those works are not enough. For example, the Oxford English dictionary records 14,070 separate meanings for the 500 most used words in our language. That's an average of 28 separate meanings per word! Obviously, it is of tremendous importance for us to select words that mean the same things to our publics as they mean to us. To do this we have to know a great deal about the people who make up our various publics — their levels of education and intelligence. Our most frequent mistake is to *over-estimate* the amount of *knowledge* people have, and to *underestimate* their *intelligence.*

No matter how high the level of intellect, simplicity in our choice of words and economy in their use is always a virtue. No message is ever so complex that long sentences and unusual words are justified. Homer condensed ten years of adventure into his epic "Odyssey" and Aristotle made a digest of it in 79 words. The Ten Commandments use 297 words.

Look through Shakespeare and you will find a hundred homely phrases that dramatically illustrate the power of simple words and clear pictures in communicating ideas. There's not a difficult word in the lot. Here are a few:

> Not a mouse stirring
> I shall not look on his like again
> Wild and whirring words
> One may smile and smile, and be a villian.

I am not, of course, suggesting that we try to emulate Shakespeare, Moses, or Homer — but we *would* do well to remember that the greatest communications of mankind have been accomplished with simple words and brief sentences.

5. *Continuity*

This is a rule which, while it can

be stated briefly is of vital importance if we are to achieve effective communication. Communication is never a one-shot procedure. Constant repetition of the facts and ideas that we wish to get across is necessary. This is a well-known and widely accepted principle in the advertising business but is sometimes forgotten in public relations. One press release, even if it results in a front page story, will exert surprisingly little influence. Repetition — constant repetition — of our message in a variety of ways and through a variety of channels is essential if we are to get our story, our facts into the minds and emotions of our public.

6. *Channels*

We can conveniently group the channels by which we communicate our messages into three areas:

Oral communication — by which I mean people speaking to people, face-to-face. This could range from the basic situation, where one man talks to another on the street, to a speaker lecturing to an audience of thousands. In this lecture we have an excellent example of this type of channel communication.

Next, we have *printed media* — which includes letters, booklets, handbills, signs, displays, newspapers and magazines.

The third group, the *electronic channels*, includes radio, television and motion pictures.

The communicator enjoys a wide choice of channels but a concurrent problem is choosing the *best* channels for his purposes. Probably because public relations owes much of its heritage to the newspaper world, and because a majority of public relations practitioners have been daily newspaper reporters, that medium tends to be the preferred and still-dominant channel. For this reason it is important for every public relations worker to keep in mind that there is a wide choice of channels and that the daily newspaper is often the least important channel — if the objective is to get the message through.

In setting up your communications program you should start by seeing if you can plan for the use of all three groups — oral, printed media and electronic. For example, meetings, publicity through local dailies and weeklies, and paid time on radio and television stations might be a sample selection from the three groups. Having made this selection, with due regard to the people who will be reached by these channels, you will find yourself confronted with cost. Almost invariably this will require you to start trimming.

What do you cut to bring your costs within the budget? You may find that you will have to cut down so much that your communications program isn't likely to be effective. In this case you should try to get a bigger budget. Remember, the basis of your reasoning here is that communications do not take place if your message does not get through.

To carry out a communications program of *some* effectiveness here are a few basic rules:

1. In general, newspapers, radio and television will give you the broadest audience for your message.
2. Television is by far the most influential of the mass media.
3. Oral communication is more effective — with those reached — than any of the mass media.
4. The closest thing to oral or person-to-person communication — personal communication in print — ranks ahead of the mass media.
5. Of greater effectiveness than any single one of these channels is the employment of more than one. The more you use, the better the chance of your messages getting through.

7. *Confirmation*

One of the most difficult problems, and one that always confronts the communicator, is trying to confirm whether his messages get through. In other words, is he in fact communicating? How many people in his public are actually hearing or reading his messages? How many people, who hear or read his messages, are being influenced by them? If they are being influenced, how strongly? Are they being influenced in the way that the communicator intends?

These are very tough questions but if we are to communicate effectively we must strive to find the answers. It gets more difficult to find the answers as we proceed through the various levels at which we communicate — as we reach out for more people and become more remote from them.

When we are communicating on a person-to-person basis, confirmation is relatively easy. Our audience can, and almost invariably does, talk right back to us and in this way we should be able to determine quite satisfactorily how effective we have been. However, since we can rarely afford the man-hours for this type of communication we seldom have the opportunity for such sure confirmation.

The same thing applies to small group meetings — a highly effective situation for communicating. Application of the principles of group dynamics permits us to gauge the reactions, attitudes, and emotions of the group after we have communicated. Again, the use of small group meetings is limited when our principal concern in public relations is publics composed of large numbers of people.

The next level is with a crowd situation where there is usually little opportunity for the audience to show its response. A lecture to a large audience is a good example. Here, there are ways of confirming the effectiveness of our message not always apparent to the casual observer. Members of the audience communicate back to us by the way they hold their heads, by their posture, by the way they sit, by their facial expressions, by their body movements and by their degree of wakefulness. Occasionally the measure of their receptivity is much less subtle, ranging from coughing, chair shifting, loud yawns or even growls of indignation. I should also note applause, nodding of heads in agreement, or even wild cheering.

The next level is when we communicate to an audience with a *canned* message — for example, a motion picture. Here the means of confirming whether our message is being received is even more difficult. If a motion picture or other canned message is used as a basis of discussion with a competent observer present, the opportunity for measuring the feed-back greatly improves.

When we come to the level that we usually use — through the media of mass communication — we encounter the greatest difficulty in confirming whether our messages are getting through. There are times when we get very definite answers to the question: "Is Anybody Listening?" Political parties get their answer by election or defeat.

Most of our communications programs are not directed — in the short term — to such clear and definite outcomes. Even if they are, we do not want to wait until votes are cast or great decisions made to find out whether we are communicating effectively. There are a number of practical tools of measurement available.

No communicator in public relations should be without a *press clipping service*. In this way he can at least find out what use is being made of his communications. This is a most imperfect way of assessing results. All he knows is if his messages are being printed; he still has no idea of whether they are being read. He can check for editorial comment, which is useful at times in judging the impact of his communications. Caution is necessary in using this measurement. The days are long past when editorial comment has reflected the opinion of a newspaper's or magazine's readers.

We have available several types of *research* which, used with judgment, can be of help. A growing number of public relations people are using what they call "Operations Research," which is merely the application of the fundamentals of good communication as a yardstick for measuring their communications programs. This, however, still does not give us the answer as to whether our messages are getting through. It *does* tell us whether or not they are *likely* to get through — and that is important.

Within the limitations of the budget you have available *opinion and attitude surveys*, and all their variations. These can be of great help in confirming whether your communications programs are working. There is no fundamental in communications more important than this.

This whole field of communications is as yet far from scientific. Many of my conclusions, I am quite sure, are open to debate. Much research of a practical nature is going on, but the day is still far off when we will have an indisputable knowledge of the fundamentals. Nevertheless, we must use what we do know of these fundamentals in our day-to-day task of com-

municating in public relations. Let us never forget that all the press releases, all the yards and yards of press clippings, all the booklets, reports, films, pictures, radio and television features, news items or mentions that we can produce in our communications programs are not worth anything if we do not get our messages through to our publics.

Lest any of us make the easy assumption that by virtue of putting our messages into print we *are* getting them through, it would be well for us to recall some results that have been reported. The *Toronto Daily Star* carried the following in one issue:

> A questionnaire which this newspaper prepared in cooperation with the board of education contained 25 queries on simple facts of local, national and international current affairs. Of 200 grade 12 students tested in three Toronto collegiates:
>
> 95 per cent did not know that Howard Green is Canada's Minister of External Affairs.
>
> 85 per cent could not name the premier of Manitoba.
>
> 70 per cent could not place Mr. Duplessis as a former premier of Quebec.
>
> 70 per cent did not know what office Maj.-Gen. George P. Vanier holds.
>
> 40 per cent did not know what the DEW line is.
>
> All told, the 200 pupils made 1,840 wrong answers.
>
> With all the mass media of information now available to students, and with the refined curricula and methods of teaching, the students' ignorance is dispiriting and perplexing. There is no lack of political news and views. Do 19-year olds never read or hear them?

LISTEN!

SISTER MURIEL, B.Sc.

Have you ever watched a small group of people talking and wondered to yourself who was listening? Others have wondered too!

THE CONVENTION of the Catholic Hospital Association had as its theme "Communications." Having attended it, I am firmly convinced that 80 or 90 per cent of our problems in educating student nurses and in nursing service stem from our inability to communicate well. The bright side of this picture shows that there is a cure for this. While the "fever is on me" I want to share with all nurses the helpful information I received at this convention, with special emphasis on the much-neglected subject of "Listening."

"Communications in the Hospital" was treated skilfully by a number of experts from the educational field, the business world, the militia and from hospitals. For the first time in my life I realized that I am not a good listener. Neither are you, unless, of course, you are really exceptional. Yet, we were told that about 45 per cent of our communicating time is spent in listening. If we were asked if we think listening is important we would likely admit that it is, but we do not act as though it were. We are not willing to give up time to become better listeners.

Who listens? Watch a group of four at a table and you will see that three of them are talking and one is waiting to talk. Parents do not listen to their children. Employers do not listen to those employed. According to statistics about one half of an audience listens to the speaker. In grade I, 90 per cent of the pupils listen to the teacher. The proportion of listeners diminishes as the children get older until we find some 29 per cent of grade XII students listen to the teacher. Who knows what happens after that? It appears that teachers in universities and schools of nursing fight a losing battle!

Is listening really so important? Let me answer this by asking another question. Is communicating important?

Sister Muriel is a member of the faculty of the School of Nursing, St. Mary's Hospital, Montreal.

Everywhere that we find two or more people together we necessarily find them communicating; yes, even if they are not speaking. Communication is simply an emotional relationship of trust and understanding between you and someone else. It is a proven fact that you and I and all other human beings function adequately and securely in direct proportion to the emotional support we derive from those we work with. In other words, how we function depends on how we and our co-workers communicate. If we put ourselves in the place of those giving the emotional support which enables others to function well, is it not easy to see that communicating is all-important? A competent public relations director, Mr. Dan Forrestal of the Monsanto Chemical Company, tells us that the way one learns to communicate is to listen.

How should we listen? How do we listen?

Listening is thinking about what you hear. It implies a desire to make a mental effort, to evaluate what you hear and then to respond. Listening actively is a difficult task. The Quaker recognized this when he started his lecture by announcing: "I am here to speak and you to listen. If you get through before I do, raise your hand."

Most of the time we speak and act as though listening were a purely passive affair. It is not. It requires conscious, directed effort. Even at that, we remember only 50 per cent of what we hear immediately after listening to an informative talk; less if the talk is not of an informative nature.

Let us examine together some reasons for our failures at listening.

We agree, do we not, that so much of what we hear is trival. We are swamped with words. What is important is cluttered up with verbiage so that we tend to pay no attention to what is said and we miss the important messages.

There is a prevailing cynicism about listening which has subtle, deleterious effects on every one of us. Because "nobody listens anyway" we don't bother even to listen to ourselves. The result is that we have no notion of what we are talking about. An authority who became interested in communication because he was a stutterer, made the observation that most serious troubles in communication arise from those who speak fluently but who become disorganized when they talk. They do this because they talk without listening to themselves.

A major error is our tendency to pay so much attention to the person speaking that we fail to listen to what is said. The tendency is greater if the persons involved are on a different status level. The man who told his wife, in speaking of his top executive, "It only takes a quarter of a turn of the big wheel to set me spinning" is almost sure to lose about 80 per cent of the message this top executive tries to get across to him.

Our language presents another difficulty. We often use words in such fashion that they mean just the opposite from what we intended them to mean. Small wonder messages go awry!

The inadequacy of our language to convey what we want to convey is increased by people adding their own neurotic fears to what they hear. One outcome of this is to react to only a part of a message, ignoring the essential part. An incident, illustrating this, occurred at Cleveland

> It was announced over the air in a certain section of Cleveland we will call Section A, that a tornado was expected to strike a certain territory we will call Section B. The announcer emphatically stated that Section A would not be involved. The message was meant to be a reassurance to the people in that area. Immediately after the announcement the station was bombarded with telephone calls from the very people whom they had hoped to reassure. Everybody in Section A asked, in a panic, what time the tornado would strike.

A large share of the problems of listening is due to hostility. People listen either self-defensively or aggressively. We tend to translate into our own mood what the speaker says. There can be no communication where these conditions are present since the trust and understanding which makes communication possible is missing.

We are moving into a new era: the era of the spoken word. The power is being shifted from the writer to the manipulator of sight and sound. We are the most "talked-to" people in

history. What we think, and so much of what we do, depends largely upon what we hear. A meditation on the seriousness of the situation would probably be the first step towards a solution. We will continue to shift along, with a deaf ear to what is intended to develop and perfect us, unless we decide right now that it is high time we became intelligent, selective and discriminating listeners.

If we had anything approaching an adequate notion of how little we know, we would certainly make the effort and take the time to listen. If we pondered over the fact that we can know only the limited part of reality that is manifested to us through our senses; that much of this is lost to us due to prejudice, language form, anxiety and moods; if we would realize that we think about that which we can talk about and that we can talk about that which we hear; surely then we would do all we could to become better listeners.

Anyone who has anything to do with planning a curriculum from grade one up even in the school of nursing, should feel responsible for making up for the neglect of the past by putting as much emphasis on listening skills as on reading skills. Every professional curriculum would be the better for including listening training. Improvement of listening habits could quite easily be accomplished by having frequent tests in listening, during a class, after a lecture or following a discussion. On-the-job training for listening has met with excellent results in some industrial firms.

There must be training. Nevertheless, when all is said and done, skill in listening, as in so many other everyday things, is bound up with mind and heart. Communicating, after all, is simply a question of living out our charity, of giving real assent to the dignity of every person we meet. For there is no meaning in words; it is people who mean.

In Memoriam

Frances (Collins) Bellwood, a graduate of the General and Marine Hospital, Collingwood, Ont., died September 27, 1960. She had engaged in private nursing until recently.

* * *

Maud Ursula (Gardiner) Brown who served during World War I with the Canadien Army Medical Corps died on October 18, 1960. She received the Royal Red Cross in recognition of her contribution. Mrs. Brown was the first president of the London unit, Nursing Sisters' Association and an honorary president of the London branch, Victorian Order of Nurses.

* * *

Lela (Ludlow) Campbell who graduated from the General and Marine Hospital, Collingwood in 1923 died August 10, 1960.

* * *

Elizabeth Rousseau, a graduate of Notre Dame Hospital, Montreal in 1915, died late in 1960 after a long illness.

* * *

Marie Sheridan who graduated from St. Boniface Hospital, Man. in 1914, died on September 27, 1960. She had served as a nursing sister for four years during World War I.

* * *

Sister Marie Hermogène who graduated from St. Jean de Dieu, Montreal in 1934, died October 19, 1960. She was a head nurse at Hôpital du Sacré Coeur, Montreal.

* * *

Florence May Smith, a graduate of Kahler Hospital, Rochester, Minnesota in 1925, died on September 3, 1960. She had engaged in private nursing in Ontario for several years.

* * *

E. Muriel (Ouderkirk) Warner who graduated from the Ontario Hospital, Brockville in 1932, died September 24, 1960. She had been active in her profession until illness forced her retirement.

* * *

Mary-Jane (Hendry) Wiggins, a graduate of the Children's Memorial Hospital (now Montreal Children's Hospital) in 1923, died September 1, 1960.

Mass Surveys and Tuberculin Testing

FLORIS E. KING, B.Sc.N., M.P.H.

A detailed report of the methods used in organizing and conducting a campaign, in Victoria County, Ontario, to secure the cooperation of every individual to be tuberculin tested.

THROUGHOUT THE PAST YEARS in Ontario there has been a vigorous antituberculosis campaign carried on in such areas as chest clinics, mass survey — x-ray and tuberculin testing, for hospital admissions and persons in jails. Other special groups x-rayed have been: recipients of public assistance, foster parents, bush camp workers, applicants for work in industry, food handlers, barbers and hairdressers, and school board employees. Along with this extensive case-finding program has been the great improvement in treatment with the extensive use of antimicrobial drugs.

Through studies conducted by the Division of Tuberculosis Prevention, Ontario Department of Health, it has been found that the tuberculosis infection rates in Ontario are different for the different age groups. For the Canadian-born whites, who constitute just over 80 per cent of the population in Ontario, the rate is only 2 per cent for all those under 20 years of age. There is a fairly steady rise to a peak of 50.9 per cent at the age of 55 and then a fall in the rate for the older age group. For a working summary, the rate of tuberculosis infection between 20 and 39 years of age is 22.4 per cent, and for all those over 40, 43.7 per cent.

Consequently, only a relatively small minority of the Canadian-born white population reacts to tuberculin. This in itself can be dangerous as a large segment of our population is devoid of the benefits of acquired resistance to tuberculosis.

There is, therefore, an increasing number of people who can easily be infected with tubercle bacilli. If, through changed conditions, this population was challenged with widespread tuberculosis infection, a serious epidemic could develop.

With these considerations in mind the ideal program of tuberculosis control in the community should include very extensive and careful supervision of potential sources of infection as well as the knowledge of the tuberculin status of each individual.

In Victoria County such a program has been set in progress. In August 1959, the Ontario Department of Health opened a special chest clinic in the new government building in Lindsay, to serve Victoria County. The task of this clinic is *total control* with *eventual eradication* of tuberculosis from Lindsay and the County of Victoria.

To launch this all-out effort, a tuberculin testing and x-ray project was organized by the Victoria County Tuberculosis Association in coordination with the Ontario Department of Health and the Ontario Tuberculosis Association, with the backing of the medical profession in the county. The objectives of the project were three-fold:

1. To demonstrate the possibility of organizing a county in order to initiate a continuous follow-up program, with the eventual goal of tuberculosis eradication.
2. To tuberculin test each man, woman and child in Victoria County.
3. To demonstrate the function of a health education consultant in a county project.

Victoria County

First, what is Victoria County like? It is a predominantly rural area with a population of 28,000. Lindsay is the largest town with a population of 10,000. The approximate area of the county is 880 square miles. A rugged area spotted with many lakes, this is a very popular resort in the summer months. The population of Victoria

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Miss King, who is health education consultant with the Ontario Tuberculosis Association, presented this material in an address during the 1960 convention of the Canadian Tuberculosis Association.

County actually doubles at that time. The winters are severe and many homes are isolated throughout that season. The frost-free period for the year is roughly 120 to 140 days.

The Organization

As the first step in the project was to have all 28,000 residents of Victoria County tuberculin tested, the basic organizational plan of the Survey Division, Division of Tuberculosis Prevention, Province of Ontario, was put into action. It is a very sound and well thought out plan.

The head executive was set up in early August. Premier Leslie Frost served as our honorary chairman. A letter with his signature went out to each one of the volunteers. The president of the Victoria County TB Association served as general chairman, with the executive secretary acting as the general secretary for the project. Members of the local TB Association made up the remainder of the executive: Vice-chairman of training, who was in charge of Training Nite; vice-chairman of professions, who kept the medical profession, lawyers and dentists informed of our activities; and the vice-chairman of public relations, who was responsible for having a school chairman, a speakers' bureau and three publicity chairmen. As health education consultant, I served as coordinator between the Department of Health, the Victoria County TB Association and the Ontario TB Association. I was also coordinator between the executive of the project, which met every two weeks, and each of the 21 area chairmen and their committees.

Victoria County was organized into the 21 areas with an area chairman and his committee in each area. Each area had 12-1400 population or approximately 300 families. The reason this number was selected is that it is a convenient-sized group to handle on one clinic day. The area chairman in each area set up his committee which consisted of:

1. *A clinic chairman* who selected the clinic site in his area and arranged for staffing it. There were 10 volunteers for the *giving* clinic and 14 volunteers for the *reading* and *x-ray clinic*.
2. *A supply chairman* who looked after the supplies for this area, such as visitors' supplies and clinic supplies.
3. *A publicity chairman* who reported all meetings to the coordinator and put up the posters and arrows in his area.
4. *A census poll chairman* whose big job it was to break down his area into three zones of approximately 100 families each. Each zone was again broken down into four territories each of which meant approximately 25 homes. The captain of each territory selected five visitors, each of whom was responsible for approximately five homes. Thus, most of the homes in the county were visited by these volunteers. All told, we had 1702 volunteers.

As stated, this organization started in August, 1959. In September, there was a large Training Nite when all of the area chairman came to Lindsay for their briefing. From then on it was their responsibility to prepare the visitors for the visits in the homes.

The industry clinics were held during the first two weeks in November. The area clinics started the middle of November in the most northern areas and were concluded in Lindsay by the end of December.

Educational Factors

The public relations factors may be summarized as follows:

1. The newspaper coverage started the beginning of August. Releases in the three newspapers in Lindsay and other local papers were extensive. News releases, interviews, personality sketches, personal appeal stories, and paid advertisements were included.
2. The radio station in Lindsay was most cooperative; personal interviews, news announcements and paid advertisements were used.
3. Television in Peterborough was also utilized; personal interviews and news releases plus paid film releases were on view.
4. The 60 school boards were contacted, after which each school teacher received panphlets and lesson plans for her class. A poster contest was conducted and films were shown.
5. At each of the four fall fairs throughout the county a booth was manned and literature was distributed. One area chairman organized a TB float which, by the way, won a prize at the fair.

6. Speakers were sent to Home and School meetings, church groups, men's and women's organizations throughout the county: 109 meetings were addressed between September and November.

7. A display was erected at the town hall — a rocket going to the moon with the moon representing 100 per cent participation. As the survey progressed, the rocket moved up by percentage of participation.

8. A weekly newsletter went out to each of our 1702 volunteers. This kept everyone informed about what the other fellow was doing.

9. The visitor, who was equipped to answer questions as they arose, left literature in each home explaining about the tuberculin test.

10. A kick-off dinner and an official opening were held to give the project the final push, with Premier Leslie Frost receiving his tuberculin test.

11. A telephone committee was organized for the last two weeks that the clinic was in Lindsay, because of the poor attendance in town. Many families were personally recontacted in this way.

12. Evaluation questionnaires were circulated to each area chairman following the initial project. Many helpful suggestions were received.

The greatest problem we had to contend with was the blizzard conditions we had throughout the survey.

The Results

In the previous year there had been only 22.8 per cent participation in an x-ray survey. In the 1959 survey, there were 16,590 participants or 59.2 per cent. Participation in the rural areas and in industry far surpassed that of the town of Lindsay. One rural area had 96.9 per cent participation whereas Lindsay and area had only 48.8 per cent.

As this is a continuous program the chest clinic is now holding follow-up clinics on those who *have* been tested and need re-checks. The Victoria County TB Association is concentrating its efforts on those who as yet have not been tested — the so-called delinquents.

In January, 1960 the executive of the project was reorganized into a permanent structure with the objective of testing the remaining untested folk in Victoria County. As coordinator, my function now is purely advisory. In the following four months 1,658 more were tested which brought the percentage up to 65.1 We still have 34.9 per cent to go. Letters are going out to the delinquents and telephone committees are being set up in each area. All the rural areas will again have clinics in the autumn of 1960. These clinics will have as their purpose:

1. To concentrate on and to call in all the people who are still not tested — the Victoria County TB Association has these records.

2. To assist in the follow-up program of the Chest Clinic which at this time will also do tuberculin testing rechecks on the children and adults who were negative and x-rays on those who were positives. The Chest Clinic keeps all these records.

After this round of clinics is completed in December, 1960, it may be necessary for the local association to take an even more serious look at the remaining delinquents. At that time we may find it necessary to concentrate on having nurses go door to door to make a last all-out effort to get 100 per cent of Victoria County tested. This remains to be seen. However, what we do know now is that we must make every effort possible to get these delinquents tested — and this is going to be a full-time job.

Once all delinquents possible are done, the Victoria County TB Association will again re-evaluate its efforts and by working very closely with the Chest Clinic will assist in every way possible in this continuous follow-up program of complete control with eventual eradication.

To date eleven new cases of tuberculosis have been found directly or indirectly as a result of the survey compared with four cases during the previous year. Already one person who was negative in November 1959 and is now positive, is under treatment. Of the total tested 16.3 per cent were found to be positive.

The total cost of the initial survey (Aug.-Dec. '59) for the Victoria County TB Association was $3,167. This does not include the OTA expenses or those of the Health Department.

As a continuous follow-up program

is the key to future control with eventual eradication of tuberculosis, we hope our efforts in Victoria County will be of some assistance in further achievements of the double-barred cross crusade. The local association, the Health Department and the OTA make a wonderful team. I know that as we work together we will achieve much.

Is Nursing a Profession?

W. Ross Upton, D.D.S.

A review of the principles embodied in the International Code of Nursing Ethics verifies the assumption that nurses may justly confirm that they belong to a profession.

You may possibly feel that it requires a great deal of impertinence for a member of another health profession to ask the question — "Is nursing a profession?" Had it been practical, I would rather have chosen the title — "Are you, as a nurse, a professional person?" I would then have suggested that you follow this up by asking yourselves, individually, another question — "If I, as a nurse, am a professional person, what is it that makes me so?" If you were to refer to Gould's medical dictionary you would find the following explanation of the word "professional" — "pertaining to a profession, especially to the medical profession; in keeping with medical ethics."

A very famous member of my profession recently stated that, to his conservative training and belief, the very soul of a true profession is its ethics.

In days such as these, when we are experiencing international crises, when governments on all sides are preparing and promoting plans of state medicine, when pressure groups are undermining our professional ideals in an attempt to not only dilute but sometimes remove altogether the standards of training in the health professions, when the "do-it-yourself" kit has become not only a household word but the professed solution to all the troubles of mankind today, we of the health professions must re-assess our positions, and re-dedicate ourselves to those ideals without which our particular calling is just another avocation. Each of us in the health professions has the duty and moral responsibility to see that the public opinion of our services is kept on the highest level. It is surprising how often a person's interpretation of the word "ethical" is synonymous with the definition of the word "legal." That same person is likely to consider as legal, any conduct that he or she can get away with without being caught. A professional person must be fully cognizant of the fact that while an ethical procedure is always legal, there are many instances in which a legal procedure is not ethical.

This discourse then, will have nothing to do with Nursing Acts nor with nursing curricula. No two nursing acts are the same. Neither are there any two separate nursing schools, anywhere in the world, that have exactly the same curriculum, nor for that matter, identical approaches when confronted by similar problems in educating tomorrow's nurses. The common denominator of all nurses is not the starched cap nor the neat uniform. It is not the proud wearing of her school pin, nor the full knowledge of what constitutes a break in sterile technique. It is not the ability to make a patient comfortable, nor to satisfy

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Dr. Upton holds the position of Executive Secretary in the combined office of the College of Dental Surgeons of British Columbia, the British Columbia Dental Association and the Vancouver and District Dental Society. Dr. Upton delivered this address at the convention of the RNABC last year.

the whims of the superintending physician. The common denominator of all nurses can best be defined by those principles laid down in the International Code of Nursing Ethics, which were adopted by the Grand Council of the International Council of Nurses at São Paulo, Brazil, on July 10th, 1953.

The Universal standard encyclopedia describes ethics as "that study which treats of the nature of morality and which attempts to systematize such conceptions as the motivation and the ideal aim or "summum bonum" (highest good) of moral conduct." As a branch of philosophy, ethics is the moral aspect of a theory of reality and is, therefore, integrated with the other branches of such a theory. It is concerned with the good, as logic is concerned with the true, or esthetics with the beautiful. Morals are specifically ethics in practice. The distinction between morals and ethics is evident in the development of human society. In ancient China the maxims of Confucius were accepted as a moral code. During the period of the great Greek philosophers, beginning about the 6th century B.C., moral behavior began to be the subject of theoretical speculation which led to the concepts of philosophical ethics. Socrates maintained that virtue is within man if he will only look for it. Plato looked upon ethics as an immutable part of his cosmology — the greatest of the Platonic Virtues of Wisdom, Justice, Temperance and Courage came to be known as the Cardinal Virtues. The ancient Hebrews and Egyptians also had investigated the fundamental problems of ethics by the time the Christian era had begun.

This encyclopedia goes on to state that the triumph of Christianity brought with it the concept of God's will as a criterion of human conduct, and "good" was put forward as obedience to Divine law. Christian ethics was strongly influenced by Greek philosophy for the fathers of the church, most of whom were scholars and philosophers, endeavored to combine theology and speculative philosophy into a complete universal system and way of life.

So you can see the discussion of ethics is not new, but, as wisely said by Dr. Frederick T. Moorless, Jr., "the wisdom of the ages renews its force when again said convincingly." There is not a code of ethics in existence which does not have its fundamental principles relating to the Bible, but it is quite possible for the nurse who is of the Jewish or Mohammedan faith to be a more professional person than the nurse who is a professed Christian. The acceptance of the International Code of Nursing Ethics by the nurse is an individual matter and depends upon the individual nurse's personal philosophy of life.

One of my most valued friends among nurses, in discussing this problem with me, said:

> The International Code of Ethics is taught in our school along with two courses in professional adjustments, one in the first year, with the senior course in the third year. We spend 10 to 12 hours on this important aspect of professional life at the end of the senior course when the students are ready to really grasp its implications and significance. It is presented by four panel discussions: the first is devoted almost entirely to the philosophy; then follows a thorough study of each of the statements. The height to which these young women rise, and the searching, penetrating analysis of the Code fills me with amazement as well as pride. Three judges sit in on these panels for the purpose of evaluation, and the faculty gives a small trophy to the best panel. We have noticed quite a different attitude on the part of the young graduates. It is gratifying to find them turning to the Code for guidance when any situation arises which may be difficult to handle.

I heard recently of a psychiatrist who said that he always endeavors, before he begins his treatment, to find out from his patients what their goals in life are. If they haven't any, he is forced to tell them that he cannot help them. This, to me, is a very sound approach and one which I submit to you for your personal consideration. There is a great need today for us, as professional people, to clarify our own personal philosophy of life. One of the most effective means is to sit down with pencil and paper and record our own goals. It can be a

pretty severe form of mental exercise because it cannot be done without a great deal of soul-searching. Honesty and integrity are the key factors of the nurse as a person, and if she will accept the need to analyze her judgment and actions according to honesty she will come closer to the application of the Golden Rule.

Arnold Lancaster of Great Britain, writing in the *International Nursing Review*, stated that the International Code of Ethics is not a list of rules to be learned parrot fashion, but is rather a way of life for a group of people with a common purpose. It is based on a respect for life, a respect for conscience, loyalty, honesty, mutual trust, and the need of people for people. A professional person must always be an idealist but, Mr. Lancaster says, she need make no apology for high standards because an ideal which can be reached too easily is always in danger of becoming a resting place.

Gertrude H. Swaby of Jamaica, in the same journal, cautions nursing educators concerning their attitudes. She points out that the nursing instructor who cannot get along well with her colleagues cannot teach the 11th principle of the International Code which speaks of cooperation and harmonious relationships. Neither will the student nurse who senses autocracy in the classroom or the hospital ward be receptive to lectures about "the essential freedoms of mankind." Beware of the nursing educators on your staff who achieve their ends by engendering fear in the student nurses rather than by creating respect for themselves! Pity the nursing instructor who cannot stimulate the building of a personal philosophy of life by the student because she herself is totally incapable of seeking out a philosophy of life.

In the field of the practical application of the Code of Ethics we are rather reluctant to be too specific lest we detract from the idealistic approach which the Code so effectively represents. However, unless we cite examples, it is possible to remain off in the clouds with respect to the problems which confront all administrators of the health professions. Therefore, I will attempt to provide a few instances.

Unjust criticisms and careless remarks by a nurse can be the cruelest of all weapons, whether these remarks are confined to other nurses or include members of other health professions. The nurse's purpose in life, at such a time, should be to elevate the position of nursing not to lower it. So often you can be asked by some well-meaning patient — "Is my doctor treating my case correctly?" At such a time you are required to exercise extreme tact and patience. Remember, what you say may not be nearly so important as what you leave unsaid. You must guard at all times against what I shall refer to as the "raised eyebrow technique." I like to use as an example the form which the hand takes when the finger of accusation is pointed at someone else. Always remember that *there are three fingers pointing back at yourself!*

There is a famous statement that General Robert E. Lee made to his son: "Duty is the sublimest word in our language. Do your duty in all things; you cannot do more, you should not wish to do less."

The Principles of the Code

The first principle of the Code of Ethics states that the fundamental responsibility of the nurse is threefold: to conserve life, to alleviate suffering and to promote health. The second principle states that the nurse must maintain at all times the highest standards of nursing care and of professional conduct. With only a slight change in wording these principles apply equally to any health profession. The third principle points out that the nurse must not only be well prepared to practice but must maintain her knowledge and skill at a consistently high level. Subscribing to and reading diligently the appropriate journals of your profession will always be an important part of the nurse's duty to her patient. We have seen the advent of the sulfonamides, the antibiotics and cortisone, to mention only a few. Each member of the health team must keep abreast of these modern developments if she is to realize her full responsibility.

Principle no. 4 refers to respect for the religious beliefs of the patient. One seemingly unimportant mistake here, when the ward is busy, would be to

neglect to see that the Roman Catholic patient received his Friday fish; similarly, the member of the Hebrew faith should never have to call attention to the fact that he cannot eat the pork you have just served him. Another example is the reverence which the Seventh Day Adventist shows for his Sabbath, which possibly occurs on a different day from yours and mine. Unimportant, you say? The religious beliefs of an individual are never unimportant.

The fifth principle requires you to hold in confidence all personal information entrusted to you. Someone who works in a doctor's office will possess the knowledge that poor little Mary Jones is about to become an unwed mother. Others in the O.R. will be in attendance when the incision discloses that Mrs. Smith has a terminal cancer and has only months or weeks to live. These are confidences. You must never betray them.

Principle no. 6 requires that you recognize not only the responsibilities but the limitations of your professional functions. True, there will always be emergency situations when you must, on the spot, render the treatment which the occasion, combined with your best judgment, demands. This principle of the Code states that you should report such action to a physician at the earliest possible moment.

Principle no. 7 bespeaks your intelligence and loyalty in carrying out the physician's orders. He is responsible for the diagnosis and treatment of the patient, and his treatment plan must be adhered to strictly. This principle also mentions unethical procedures. A nurse who finds herself expected to assist in any illegal operation must, firstly, refuse such assistance and, secondly, see that the matter is reported through the proper channels open to her.

In principle no. 8 the nurse sustains the confidence in the physician and other members of the health team. She *sustains* that confidence, she is careful not to undermine it. The nurse may find herself in the position of witnessing an unethical procedure: the removal of an unduly high percentage of healthy appendices where inadequate pathological services are available; or the tying off of Fallopian tubes casually included in another abdominal operation but not mentioned on the patient's history. Observation of such unethical procedures are never a matter for common gossip, but should be reported immediately to the proper authority, be it the director of nursing, the administrator or the chief of the surgical staff.

Principle no. 9 deals with the nurse's remuneration which too often is found to be inadequate. The important section of this principle, however, is that she accepts only such compensation as the contract, actual or implied, provides. She must never condone being part of a dichotomous or fee-splitting procedure. Some nurses may often find themselves in the position of referring patients to certain doctors. No fee nor gift must ever be received by the nurse for so doing, if she is to remain within the bounds of reasonable professional ethics.

Principle no. 10, common to all health professions, restricts the nurse from associating herself with the advertising of products, or with any other form of self-advertisement. The prime concern of a member of any health profession is the health of the patient. When advertising is resorted to in any form, the concern shifts from the health of the patient to that of financial reward.

The remaining principles of the Code stress the importance of maintaining harmonious relationships, of living a private life which is an example and credit to your profession, of conforming to the accepted patterns of behavior of the society and the community in which you live, and of your responsibility to other citizens in promoting efforts to meet the health needs of the public. This last principle is a most important one for the nurse who has traded her life of caring for the patient for one of looking after a husband and children. Even though she no longer takes an active part in helping to earn the family income she may, in her community life — be it with the church, the Home and School, or the Council of Women — use her professional knowledge and her training in the handling of people to further the public health of the community in which she lives.

In closing, I would go back to the

question which is asked in the title of this address — "Is nursing a profession?" In answer to that question I would emphatically say "yes." But, it could be a greater and stronger profession if 100 per cent of its members, instead of only 99, lived the Golden Rule instead of merely committing it to memory. The superstructure of professionalism collapses unless it is well secured to the firm foundation of a well defined Code of Ethics.

PHILOSOPHY AND CURRICULUM

FLORENCE E. ELLIOTT

To assist schools of nursing in upgrading their educational programs, the CNA has been working towards the development of a curriculum guide. This is the last of a series of four articles on this topic.

IN A STUDY OF CURRICULUM development there must be a foundation of beliefs concerning educational programs, their implementation and their evaluation. The activities of the School Improvement Program of the National League for Nursing are founded upon the following basic viewpoints:

1. The responsibility and the authority to develop the educational program of a school should be delegated to the faculty.

2. The faculty must assume *full* responsibility for developing a curriculum within the over-all prevailing beliefs of the controlling institution.

3. This responsibility encompasses all of the learning experiences that are provided both in the institution offering the program and in any other affiliating agency.

4. The curriculum in basic nursing, concerned as it is with the development of a nursing practitioner, has a single unifying purpose. Therefore it should be planned as a coordinated whole. There is no place for a compartmentalized program in which the faculty does not seek continuously to help the students to see the total relationship between individual courses and the larger curriculum areas.

5. The process of curriculum development should be shared by all members of the faculty so that the end result is the outcome of the efforts of the total group. Each faculty member should be thoroughly familiar with the curriculum, its objectives, and the means of achieving them.

6. The faculty must decide the extent to which it can properly expect to prepare its students with the resources available in the specific setting.

7. When goals have been determined the faculty should:

   a. Identify the major components of nursing that it proposes to teach.

   b. Define clearly what these components mean in terms of what the nurse does (behavioral objectives).

   c. Identify what the nurse needs to know or to have in order to function as prescribed.

   d. Plan the learning experiences. This includes identification of kinds of experiences needed; determination of the areas in which they can be acquired best; and organization of the experiences into logical sequence.

   e. Implement the plan.

   f. Evaluate the results by determining the answer to the question — does the student exhibit the requisite behavior?

8. All of this presupposes an organization that lays down the channels through which the faculty operates. A common pattern finds the individual instructors functioning on sub-committees of the curriculum committee. The curriculum committee receives and acts upon reports of the subcommittee and,

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Miss Elliott is the director of the study on cost of nursing education with the National League for Nursing. She presented this paper at the Curriculum Workshop, Canadian Nurses' Association in 1959.

in turn, takes its recommendations to the total faculty group for discussion and action.

These represent some guidelines for curriculum development. Now let us consider what the implications are for an actual situation.

Climate and Curriculum

It should be recognized that the climate that prevails in the controlling institution affects the quality of the educational program. This climate is the result of a number of interacting forces. Some of these nursing can only hope to affect gradually, if at all. Others fall directly within its control.

The administrative policies of the hospital, the standards for patient care, the quality of medical practice, are areas in which the sphere of influence of nursing may be extremely limited. Any desirable change in the attitudes of the administration and the medical staff toward nursing and the educational program can be effected only slowly. A carefully planned program of interpretation of modern nursing and nursing education to the appropriate groups, in conjunction with practical demonstration of effective care should provide best results. Within the nursing department there is the power and the responsibility to provide, to the greatest extent possible, a climate that will stimulate and encourage a continuous process of improvement. The key person is the nurse administrator. The degree to which she encourages teaching and nursing service personnel to ask constantly, "How can we do a better job?" will determine the nature of the climate substantially. When individuals are not satisfied with simply adequate results but are ever seeking ways to accomplish the best that is possible and where there is freedom to try new approaches, there is a healthy climate in which sound educational practices should flourish.

The Nurse Administrator

It is the responsibility of the nurse administrator to support and encourage the educational activities of the faculty. It is she who grants the faculty the freedom to explore new avenues of approach; to experiment and to wait and see what happens as a result. It is her responsibility to provide the leadership that will assist the faculty in developing the organizational structure through which it can function as a group. It is her responsibility to provide for the continuing development of the faculty, individually and as a group. Particularly in these days of shortage of qualified instructional personnel she has a responsibility to ensure that inexperienced teachers receive the guidance that will assist them to become effective teachers and productive members of the faculty group.

If she has *dual* responsibility for nursing service and education, she has a similar duty to stimulate nursing service personnel to recognize and accept the scope of their responsibility for the quality of nursing care provided. This group must be encouraged to engage in the same continuous study and evaluation of nursing care that the faculty apply to the curriculum. Most important of all, from the standpoint of the school of nursing in a hospital setting, the nurse administrator has the duty to help the nursing service staff assume full responsibility for the quality and amount of nursing service, just as the faculty assumes responsibility for the quality of the educational program. While this will mean utilization of the nursing service that students provide as a part of their educational program, it also implies acknowledgment of the faculty's prerogative to determine the *quantity and kind* of learning experiences needed to achieve the school's objectives. Nursing service personnel must re-orient their thinking so that the student group is not seen as the answer to staffing problems.

Faculty Members and Functions

Responsibility does not rest solely with administration. The individual members of the faculty have their own responsibilities for functioning constructively. Inherent within these responsibilities is the need to maintain an attitude of intellectual inquiry; to keep abreast of new ideas; to be informed about the curriculum as a whole; and to ask continuously, "Is this the best that we can do? How can we teach more effectively?" It means being "solid citizens" with strong feelings of responsibility. It means that each instructor is constantly striving to

maintain and improve her skills as a practitioner of nursing.

About Nursing Philosophy

Sound curriculum development *must* be based on an identification of what *kind* of nursing is to be taught. Too often the latter is not clearly specified. Many faculty groups have mispent hours formulating statements of philosophy and objectives for their schools simply because it is the respectable and expected thing to do. Too often the efforts have produced well-couched phrases that might be called clichés, which have been filed away to be forgotten until someone asks if the school has a stated philosophy.

Often it seems that individuals develop a mental block at the very idea of stating a "philosophy." Notwithstanding this, it is usually very easy to involve them in a philosophical discussion of nursing and nursing education. The desired objective of formulating a philosophy might be approached by seeking an answer to the questions: 1. What are our expectations for the graduate of the program? and 2. How can we prepare nurses who will meet these expectations? From thoughtful and detailed responses, it should be relatively easy to formulate a statement of the group's philosophy or beliefs about nursing, nursing education and the objectives for an educational program. This approach may be more meaningful to those who have difficulty in seeing the value of stating a philosophy.

It probably is not necessary to point out that if the statements of philosophy and objectives are to be useful and used, the entire faculty should have a role in their formulation. How can this be accomplished in view of the rapid turnover of instructional personnel? This is one reason for the importance of frequent, regular reviews of the school's statements of philosophy and objectives. Every effort should be made to insure that the terms used in the final statements have meaning for everyone and that they are interpreted in the same way.

Any consideration of a philosophy for a school of nursing should begin with a recognition of the very great social lag within the field of nursing. This difference exists generally between actual practice in nursing and that which many of our nursing leaders visualize as the potential for nursing. No doubt there are many who think that we have been operating from an ivory tower; that we have been thinking about a kind of nursing that may be highly desirable but is too unrealistic for widespread adoption. There may be validity to this view but we should avoid any use of such pessimism to evade an acknowledgement of the ultimate that can be accomplished in any specific setting. When we ponder the obstacles that nursing has had to overcome to reach its present stage, we may wonder justifiably if we would have made as much progress if as large a proportion of nurses in the past, particularly in the field of nursing education, had been as willing to accept the *status quo* and use it as an excuse for what was or was not being done as seems to occur in our ranks.

That the philosophy of nursing that a school professes, and therefore, would be expected to implement, should be realistic in terms of attainability, seems too obvious to mention. Nevertheless, numerous such statements seem only vaguely related to actual practice and attainability. Faculties apparently see the need to write statements for *others* rather than for their own use in curriculum planning. This is the reason for the erudite and highly acceptable phraseology that we find in statements of philosophy and objectives and also the reason why they repose unused in the files. The approach to the formulation of a philosophy which asks, "What kind of nursing do we wish to teach? and "What expectations do we have for the graduate?" needs to be tempered by the question, "Is it realistic to expect that we can accomplish this?" Are we realistic in terms of the kind of nursing that the students will see practised; the kind of medical practice that they will observe; the qualifications of the faculty? It would be much better to have a limited goal that can be broadened than one which lies so far beyond the possibility of attainment in the immediate future that it is promptly forgotten.

The faculty may choose to describe the nurse it expects to produce in quantitative terms. Adjectives such as

efficient, adaptable, conscientious, skillful are familiar ones. What do they mean in relation to the kind of nursing performed? Do they mean the same to everyone? How does the faculty *know* that the students achieve these qualities? Are they really the most important descriptive terms to use? These and other questions are familiar ones to nurse educators who have struggled with the problems of evaluation.

These are important considerations because the expectations for the graduate should be the guidelines that direct the faculty in the development of the curriculum. They are of prime importance when the time arrives for evaluation of student progress as well as of the effectiveness of the curriculum in fulfilling the stated objectives. Many faculties are finding it much more meaningful to formulate or amplify objectives for the curriculum through the use of terms that describe the *behavior* which will indicate that this kind of nursing is being practised.

Determination of the kind of nursing to be taught is one step in curriculum development that the faculty does not develop unilaterally. No one has the prerogative to tell a faculty how to teach or what the content should be. However, the decision concerning the kind of nursing must take into consideration what the public, the patient, the physician and nursing service expect of the graduate.

Formulation of a philosophy of nursing and nursing education is a difficult process for many faculties. Identification of behavior may be even more painful if this represents a new approach. Nevertheless, the advantages to be gained make this a worthwhile endeavor. Objectives are described with such specificity that each faculty member knows exactly what the curriculum should be expected to achieve. At the same time a built-in yardstick is provided against which to measure the degree of success in the achievement of these objectives.

Curriculum Building

When the philosophy and the curriculum objectives are clearly stated, accepted and understood by the individual members, then the faculty is ready to identify the essential knowledge and to select learning experiences (content and method). If it seems that undue emphasis has been placed on the philosophy of a school and its relation to the curriculum, this has been intentional. It is my firm conviction that too many groups omit thoughtful exploration of "what kind of nursing" and begin by looking at curriculum content before they really know what they want to achieve.

The curriculum is the design by which the faculty plans to accomplish the purposes of the school. The generally accepted definition is that it comprises not only subject matter but *all* learning experiences under the control of the school. Applied to nursing this includes all of the planned learning experiences whether they occur in the classroom or in the clinical situation. Such a premise means that while a clinical nursing course may be thought of as having two components, theory and practice, planning for the learning experiences must be in relation to both components and the objectives for the course as a whole. For example, the course in obstetrical nursing just as a course in chemistry, should include the work in the laboratory as well as the more formal work of the classroom. The clinical setting is looked upon as the nursing laboratory where experience in the actual care of patients enables the student to relate theoretical knowledge to practice. At the same time she is given an opportunity to begin to develop nursing skills. All experiences should be selected and planned in relation to each other so that they are fused into a coordinated pattern designed to achieve the objectives of the specific course and to make the required contribution to the over-all objectives of the curriculum.

When this concept of nursing education prevails, it means that the instructor in a clinical nursing course functions not only in the classroom, but does much of her teaching in the nursing laboratory. She is teaching *nursing*, not just the theory of nursing. She is responsible for the experiences that students have practically as well as theoretically. In this kind of curriculum there is no place for "two hours weekly ward instruction" with patients selected not in terms of the

objectives for the course, but in terms of the "most interesting care" on the unit. Nor is it possible simply to turn students over to nursing service personnel for "clinical experience." It means that supervision of the student in her clinical practice becomes one of the teaching methods in the same way as the patient-centered clinical conference.

If we seek to provide experiences only in terms of well-clarified educational objectives, it may eventually mean a reduction in the number of experiences. Surely those students who have been helped to develop skills in assessing a situation; to utilize their knowledge in formulating a plan of care; and to follow implementation of the plan with an evaluation of its effectiveness will not need the quantitative experiences that must be provided with much repetition. Here are some findings from educational research that could be helpful in considering learning experiences within the clinical setting:

Practice is essential to learning but is not sufficient alone.

Practice does not necessarily guarantee improvement.

Practice is a condition, not a method of learning.

Practice must be motivated. Unmotivated practice is singularly ineffective.

Short practice periods are most effective. The value of practice decreases as fatigue increases.

We find little documented evidence to justify the long periods of clinical practice that we have been accustomed to classify as learning experiences. It is a healthy situation when we admit that "we have to do this because we are committed to providing a share of the nursing service in the hospital which conducts our school." It is a matter of concern that so many of our programs remain subject to the demands of nursing service rather than to the needs of the learners in spite of our pronouncements about our beliefs in relation to nursing education and the criteria for evaluation. We often find faculty groups very honestly believing that what they are doing is completely under their control, who are completely unaware of the restrictions placed upon them by the demands of nursing service commitments. It is far better to acknowledge the facts, to seek to do the best within our limits and to attempt to extend those limits in the way that seems justified or desirable to a group or to the profession.

There is some question, too, about our integrity in our relationship to the students. We assume that many come into nursing because, economically, it represents a form of education that is attainable to them. Do they actually know how they are paying for this education and who subsidizes the portion that their services do not cover? Are they getting value received for the investment of time and energy that they are making? If there is no other way of subsidizing nursing education than by providing nursing service, might it not be possible to separate the educational experiences from periods that are frankly service? In spite of the inherent dangers contained in such a proposal and if only for the purpose of promoting an honest relationship with students from the very beginning of their educational program, there would appear to be value in having a portion of the students' experience in the clinical setting controlled by the faculty and planned in terms of specific educational objectives. This idea may be worth exploration.

To the extent that faculties assume their academic responsibilities, we will develop curricula that produce practitioners who can assume the responsibilities of modern nursing.

The School of Nursing, Dalhousie University will hold its Annual Institute in Halifax, Feb. 1-3. The theme will be Rehabilitation.

Guest speakers are Miss Alice Morrissey, Instructor and Supervisor, Rehabilitation Nursing, Bellevue Hospital Center, New York and Dr. Arthur Shears, Director, Nova Scotia Rehabilitation Center, Halifax.

The program includes presentations and panel discussions, emphasizing the preparation and education of the nurse, demonstrations, films, slides, equipment, etc.

Please advise the University if you wish to attend. Registration is $2.00.

A Tribute to Gertrude Hall

EARL P. SCARLETT, M.D.

THE DEATH OF Miss Gertrude Hall, Director of Nursing at the Calgary General Hospital, has impoverished the medical life of Canada and saddened two generations of her students and friends. She died, not in a comfortable haven of ease and indulgence, but in the full flood of action and high adventure, as nearly as possible the death she would have wished. She was among the leaders of the nursing profession in Canada, in the great tradition of a line of women whose commanding virtues were faith, moral passion, a sense of discipline and an untiring capacity for work. She was one of those who brought to full flower the institution of nursing in this country, known and prized for its excellence far beyond the borders of Canada. Today, every nurse in our land who walks the wards of our hospitals is the clear-eyed and gracious product of that fine leadership, while at the same time the whole world of medicine has benefitted infinitely, for the presence of woman in the person of the nurse has humanized medicine in all its departments.

If not quite oblivious to excellence, we as Canadians take too little account of our achievements and of our distinguished citizens. In our natural habit of complacency we take too much for granted and fail to commemorate the individuals and events of the past and present who, in their persons and activities, are forging and strengthening the texture and traditions of our contemporary Canadian life. It is appropriate then that some tribute should be paid to one who served with a single-minded devotion even unto death.

It is a singularly happy fortune that Calgary should have been the beneficiary of Miss Hall's labor and influence during the past eight years. Her character and experience fitted her for the task she took up, and she used her talents to the utmost. She and her colleagues made a strong team. They took an institution which had declined into the doldrums and in a short space of time transformed it into a vital and efficient centre in which all may have faith and pride. Working in a sphere with new dimensions, with problems which have no ready-made solution, and with the determination that values must not be destroyed by machinery, they made the hospital a centre of integrity, sympathy and technical skill.

In this process of re-building, Gertrude Hall set an example to all the citizens of Calgary which should not be lost sight of. She exhibited the creative impulse in a rare fashion. We Canadians are too much given to conformity and a cautious and critical attitude of mind. There is among us too much crying down of generous and imaginative creative enterprise. We fail to realize that reason and a timid balancing of probabilities will never release creative endeavor. For that are needed enthusiasm, high vision, imagination and a staking of all on the future. These are the qualities that Miss Hall had in fine abundance. She really cared about what she conceived to be right, she fought for it and did not roost contentedly in the snug shelter of accepted ideas. Her success has surely shown that it is these qualities that enrich a community and breed a proud and worthy civic spirit. In that reflection we may fittingly salute her endeavor.

Gertrude Hall has completed her great mission in Calgary. She has left to us a fine physical institution, a worthy spirit in its wards and a tradition of excellence in its School of Nursing. If you would see her monument, visit the Nurse's Block of the Calgary General Hospital lifting its great and strong outline above the roof-tops of this city, and look about you.

In her mission, as we have said, Miss Hall brought the knowledge and experience of a lifetime to bear on the hospital here. But she brought something even more precious — her personality and example. Her philosophy of teamwork, so apparent in her activities, was the theme of her last charge to her graduates on the eve of her

death. She had a capacity for great sympathy. She never allowed herself to become trapped or frustrated by small anxieties but resolved them in the intensity of her devotion to the cause, her tremendous zest and above all her superbly feminine single-mindedness. In these respects she was a rebuke to all those who are lukewarm in enterprises. She had anger, but it was anger only at those who betrayed the tradition of healing and particularly those who would crush anything worthwhile between the nut-crackers of their own self-assurance and their wilful ignorance of the issues involved. At all times she showed the fine vertical independence of the ideal nurse. But not in any austere way, for she was the kind of person who raised the temperature of life about her. As administrator and as the head of her company of nurses, she exhibited that finest of all qualities in a leader — grace under pressure. As a member of the order of nurses, that guild for which "God ordered motion, but ordained no rest" she discharged her commission with distinction and honor.

A glance at the transformation of the Calgary General Hospital in the last few years makes the observer realize that medical care in the modern world has become enormously complex in the wide variety of interests which must be served. It should suggest as well to every person who is jealous of the welfare of the city that the evolution of the modern hospital has at the same time increased the sphere of our responsibilities as citizens. In this evolution our consciences and our capacities as citizens must increase as well. We can no longer be satisfied with the old order in which the hospital was a voluntary institution dependent upon the initiative and generosity of citizens of good will or simply on the changing fortunes of civic enterprise and fortune. Faith in the hospital, as one of the vital areas of modern life, is not so casually or easily learned. It is bred and maintained through the determination of all concerned — authorities and citizens alike — to maintain at whatever cost high standards in this vital institution which serves all in the community. With such support the true spirit of the hospital — what in professional circles is called "the soul of the hospital" — will emerge and develop, enabling it to play its role in society as a great humanitarian centre utilizing the saving weapons and techniques of science. It was in this faith and towards this end that Miss Hall worked during her years in Calgary.

It is a privilege to pay this tribute to Gertrude Hall in the name of the citizens, physicians and nurses of this city. And looking over the writer's shoulder as he writes, one can see a long line and phalanx of grateful patients and student nurses who received inspiration from her work and presence. In the name of all these one may be permitted to place a token of respect and gratitude in the Lady-Chapel of Remembrance to a woman of the kingdom of medicine who added to the blessings of her generation.

The crown of experience in the nursing order is like the crown of Lombardy — a band of iron set in a band of gold. This crown Miss Hall came to wear with humility and proud distinction.

When a great human being dies, it is said that the immortals await the newcomer at the top of the nearest hill. In this sense Gertrude Hall has joined the company of Nora Livingston of Montreal and Mary Agnes Snively of Toronto and the other great-hearted figures of Canadian nursing, and of Florence Nightingale herself, the immortal founder of the order of patience and devotion that the world calls the nursing profession.

Surveys have shown that nearly 50 per cent of the women who go into nursing are impelled by an innate interest in helping people. They are less influenced in their choice of nursing as a career by mass appeals (recruitment programs) and by strangers than by friends and relatives. The choice of school may be influenced by outsiders.

—20,000 Nurses Tell Their Story

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Red Cross Home Nursing Classes were conducted last year by 851 registered nurses serving as volunteer instructors.

The Nurse and Parkinson's Disease

DOROTHY M. DENT

"The night cometh when no man can work." This quotation applies to everyone — some time — somehow — but to the person with Parkinson's Disease, or ***paralysis agitans,*** *the ceiling of darkness is always low.*

IN WRITING THIS ARTICLE I am acting in a dual role. I am a victim of Parkinson's Disease. I am a nurse. I cannot separate the one aspect from the other.

For a moment, let us review the anatomy of the brain. It is the organ chiefly affected by Parkinson's disease. Pinkish-gray in color, moist and rubbery to the touch, it is cushioned against sharp blows, bumps and impacts by a shock-absorbing fluid. Wrapped in three membranes, it fits snugly into the bony cranium. Its position could be likened to a flower on top of a slender stalk. The upper part of the stalk, known as the brainstem, lies entirely in the cranium. The remainder of the stalk, the spinal cord, is outside the skull but it is protected by the vertebrae through which it passes, terminating at the small of the back.

Functionally, the brain is the great organ of adjustment. It plays a biological role in helping us to adjust to unpredictable events of the outside world. It enables us to preserve our identities by swift and ceaseless chemical changes. For example, we know that sugar is an energy-producing substance and that the body requires just the right amount — no more, no less. The slightest change in blood levels could result in a biological "something" between coma and convulsion. The brain is in constant communication with all parts of the body. It could be called the headquarters of the most intricate and elaborate communication network ever devised. Its activities are dependent on the work of billions of nerve cells, the nerve cell being the living wire which produces and conducts rapid electrical impulses.

The areas of the brain affected by Parkinson's disease are the gray cell groups beneath the cortex, known collectively as the basal ganglia, particularly the bilateral *globus pallidus.* These lower centres, including the brainstem and associated nerves, play a major role in regulating blood pressure, breathing and many other automatic functions. They are also involved with "raw emotions and all primitive drives" and in voluntary muscle control. The cortex is known as the "high centre", the basal ganglia the "low centre," and the brainstem the "gateway" to the cortex which clears certain impulses for top level consideration.

We are told that there are three types of Parkinson's disease: idiopathic; a type resulting from encephalitis; and a product of arteriosclerosis that is often found in the old age group and more or less synonymous with dementia.

The nurse can play an important role in establishing an early diagnosis by keen observation and accurate reporting of every symptom noticed and every complaint voiced. I feel that no patient with this disease will ever give a false complaint. It is, to my way of thinking, as ridiculous to say that a person with *paralysis agitans* shows psychosomatic symptoms as it is to say that a person with measles shows a poor complexion! An early diagnosis saves much of the anxiety and apprehension that may contribute to the progress of the disease. In some instances, patients are advised by their physicians to wait until symptoms are well pronounced before considering surgical interference.

There is often a latent period between the onset of the disease and the development of clinical symptoms. It is in this period, when the patient is

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Miss Dent, who is a Civil Service Health Consultant in Ottawa, devotes much of her time to assisting other Parkinson disease sufferers by increasing public understanding and by encouragement.

confronted with the intangible or unknown, that he frequently reacts with fear and near panic. This is detrimental to his condition. I feel that the earlier surgery can be performed, the better the chance the patient has to resume fairly normal activities. The disease is arrested at that particular stage. Since brain tissue can never be replenished or repaired I repeat that *an early diagnosis is invaluable.*

A person with Parkinson's disease finds his whole life turned topsy-turvy — outwardly as well as inwardly. In nursing a patient with this condition, as in all illnesses and particularly in incurable diseases, the nurse should represent devoted service. She must make sure that her service brings care and comfort; supplies support and reassurance; relieves pain and suffering to the greatest degree possible.

Of the many people with Parkinson's whom I have seen or heard from, both in Canada and elsewhere, many have complained not just of vague aches but of localized pain in various parts of the body. One of the first symptoms of the disease is extreme fatigue — a fatigue beyond the understanding of any except those afflicted. Another symptom is slowness of all movements. Each motion is performed with great deliberation. For example, you may notice that in rising from a chair the patient will place both hands on the sides for propulsion purposes. Other symptoms, as the disease progresses, are shaking, muscular rigidity and lack of facial expression. This outward change of personality gives the patient a blank and very sad expression. It becomes very difficult to laugh or to express joy no matter how well developed that important characteristic — a sense of humor — may be. This loss of facial expression, in addition to possible interference with speech, adds greatly to the patient's inability to communicate to the nurse his many complaints and needs.

I recently was greatly saddened by an incident concerning a lady with advanced Parkinson's. This patient was brought from a hospital for incurables to a relative's home to meet me. Talking from her wheelchair she told me this story:

> One day when her nurse was wheeling her down the corridor, another nurse came up and began to discuss a problem. Then she stopped abruptly and looked inquiringly at the first nurse and her patient. The nurse in attendance, without hesitation, said "Oh go ahead. This patient is too dull to understand!"

I was conscious of the great hurt that had been inflicted upon her. The nurse, either through indifference or lack of knowledge, had given her patient a feeling of utter worthlessness. This should never happen in *any* illness, but in Parkinson's disease it is particularly destructive to the patient. I do not simply ask of nurses — I *beg* of them — that in the care and treatment of these patients they will try to bring to the fore all of the compassion, kindness, patience, and understanding of which they are capable. It is important that they enable the patient to be as self-sufficient as possible. But with the things that he cannot do — and they are many, such as tying his shoelaces, buttoning his coat or balancing his cup and saucer — help should be given freely and kindly.

One day, during a visit to a convalescent hospital, I witnessed a strange scene. As I started my tour, I saw a patient with advanced Parkinson's being fed. On my return that same patient was slowly, and with great deliberation, *feeding another patient.* How to explain this, I cannot. I give it to you as an observation.

Of the many people suffering from Parkinson's with whom I have had contact — and they number hundreds — only three have displayed hallucinations and mental symptoms. These have appeared only in the advanced stage. This leads me to believe that the mentality of such patients is seldom affected and then only in the terminal stage, which may happen with an advanced disease of any part of the body. Two of these patients had been in a home for the chronically ill for some time. The third had remained in her own surroundings but had had a severe fall.

Should you have a Parkinsonian patient under your care, who is about to face surgery, try to realize the enormity of his venture. Being of mature age he is usually told all, both on the debit and credit side. He would be less than human if he were not at

least slightly apprehensive. The patient is usually hospitalized and observed for a few days prior to surgery. This affords him time to adjust to his doctors, nurses, and the hospital atmosphere generally. During this interval the nurse can do much to allay the patient's fears. Not all cases of Parkinson's are operable nor do all persons who undergo surgery have similar results. We all have our individual differences, in illness as well as in health.

The surgery is done under local anesthesia. This permits the patient to be a participating member of the team of doctors and nurses, usually consisting of six or eight people. At present, the best surgical results are obtained when the muscular rigidity is more pronounced than the shaking. Following surgery the patient remains in bed for about three days. The nurse must observe him closely and carefully. She must be conscientious about reporting and recording what she observes. Blood pressure readings are taken hourly. The patient's temperature is recorded regularly since the operative site is close to the temperature control centre of the brain. Keen watch must be kept for any signs of hemorrhage. Medication is given to prevent possible convulsions. The affected side (or sides) is very weakened following surgery. The patient is warned not to attempt to get out of bed without the nurse being present. Being a nurse, I thrust aside this warning and got out of bed alone! I walked as far as the washbasin, turned on the tap, then looked at myself in the mirror. To this day I do not know whether it was the shock of my reflection or weakness, but without warning I found myself on the floor under the basin. There I remained until someone came to the rescue. It is now well over a year since I had surgery performed. I still find that deep concentration is very helpful in such activities as walking, bending and maintaining balance, talking, chewing and swallowing.

Two of the more common medications prescribed for Parkinson's are Artane and Kemadrin. The dosage is regulated by the physician and increased as needed. These medications are continued following the operation. Physiotherapy is necessary and very important in the rehabilitation of these patients, as is the moral support of family and good friends.

Remember, surgery cannot cure this disease, nor can any known medication. The patient faces an indefinite future and the possibility that more crippling effects may develop and force him to be extremely dependent on other people. To nurses I would say, be kind, be helpful, be patient, be knowledgeable. As the greatest Man who ever lived said over 2000 years ago "If ye do it unto the least of these, ye do it unto Me."

The American College of Surgeons invites nurses to its forthcoming annual four-day joint meeting of nurses and surgeons which is being held in the Ben Franklin Hotel, Philadelphia, March 6-9, 1961. As guests of the College there is no registration fee for nurses.

Sessions cover the following subjects: open heart surgery; arterial grafts; radiation and chemotherapy in the management of advanced cancer; nursing research — the intensive care unit; pediatric surgical nursing; management of a child with a meningomyelocele; management of cancer in children; the surgical nurse and the law.

Additional information about the program and advance registration may be obtained by writing to: William E. Adams, M.D., Secretary, American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

* * *

The Canadian Federation of University Women's $1000 professional fellowship is open to any woman holding a degree from a Canadian university, who is not more than 35 years of age at the time of award, and whose domicile is in Canada. The award will be based on evidence of character, intellectual achievement, and promise. Preference will be given to candidates who have completed one or more years of professional work and who desire to spend a year in an accredited Library School, College of Education, or similar professional school.

All communications should be addressed to the chairman of the Fellowship Committee: Dr. Mary Winspear, 18 Severn Avenue, Montreal 6, Quebec.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

International Exchange

Within the past year CNA has been privileged to welcome to its new headquarters many international visitors on observation study tours. In November, a true cross section of our globe was represented under the sponsorship of National Associations, the World Health Organization, Women's Missionary Society and the Kellogg Foundation. Among these visitors were FANNY SHAW, matron, Newcastle-on-Tyne General Hospital, England; PHYLLIS ROBBIE, clinical instructor, Scotland; ANNA JACOB, superintendent of nurses, Christian Medical College, Vellore, India; ELIZABETH SMYTH, senior tutor, Medical Department, Kenya, Africa; CLARICE FERRARINE, director of nursing service, Hospital das Clinicas, University of Sao Paulo, Brazil and MARIA PINHEIRO, director of the school of nursing, University of Sao Paulo, Brazil. Our opportunities to exchange ideas, problems and information on recent developments in nursing in our individual countries are ever increasing, thus fulfilling one objective of the International Council of Nurses "to foster international understanding amongst the nurses of all member countries."

Your Pension and Income Tax

Remember that February is the deadline if you wish income tax deductions for 1960 on your CNA Retirement Plan.

The greatest advantage of this plan is that your contributions to the Canadian Nurses' Association Retirement Plan are deductible from your income for taxation purposes.

Let us suppose that you have an earned income of $5,000, a year. If you make the maximum contribution to the Plan that you are allowed, that is 10 per cent of your earned income or $500, the immediate tax relief will be approximately $100. Let me put it this way. In effect, you are contributing $400, and receiving benefit of $500. Perhaps you would be interested to know how much you could accumulate in 25 years by merely saving this $100 tax reduction every year. If your money earned interest at four per cent you would have approximately $4,070, of which $2,500 would be your contributions and $1,570 would be credited interest.

Your Committees

National Office was the scene of committee activities during the month of November. The joint meeting of the Committees on Nursing Service and Nursing Education and separate meetings of these same committees have already been mentioned. A meeting of the Special Committee on Nursing Assistants was also held in November. This committee is studying the place of the nursing assistant in organized nursing. A meeting of the CNA and CHA Committee on the Extension Course in Nursing Unit Administration was held in Toronto. Miss HELEN MUSSALLEM attended the regular meeting of the Canadian Joint Committee on Nursing held in National Office in November. She discussed with the members of this committee plans for the implementation of the recommendations in the report of the Pilot Project.

Nursing in Disaster

LAURIE MCCOLL, assistant secretary

in National Office was one of the 55 directors of nursing and nurse educators from across Canada attending the course in disaster nursing at Arnprior, October 17-21.

EVELYN PEPPER, nursing consultant, Emergency Health Services, Ottawa described the philosophy of disaster nursing as the belief that every professional nurse in Canada has a responsibility to learn and understand the basis of disaster nursing, and to be prepared to act in an emergency.

"To be able to do the best for the most" requires the ability to assess and make decisions concerning priorities; the initiative to improvise and go ahead with the job at hand; and the willingness and ability to delegate everything possible to other staff and volunteers, which means teaching on the job. The professional nurse must have the ability to offset panic, to maintain a sense of humor and to uphold the morale of the nursing team and the patients.

This philosophy was fundamental in all of the related lectures, demonstrations and films on nuclear warfare and emergency health services. The essential preparedness of every hospital to perform its role in civilian disaster or in a national emergency was emphasized. Many of the hospitals represented have disaster plans that have been tested and revised in consultation with the staff of the Emergency Health Services.

There was much food for thought and discussion in the daily groups. Each group was requested, as a main objective, to answer the following questions in the preparation of a teaching plan for schools of nursing. How can the content of this course be most effectively correlated to the basic curriculum in schools of nursing? How much emphasis should be placed on the possibility of a national emergency and when should this be stressed? Is there value in group demonstration projects? How can we be assured of a continuing interest in disaster nursing following graduation?

CNA Publications

The popularity of CNA publications is gaining ground at home and abroad. Numerous requests are received in National Office for both the English and French publications. The most recent list of publications is printed in this issue of The *Journal*. The page may be used as an order form.

You may be a member who has been disappointed or even disillusioned. You may have decided that to obtain a CNA publication for a specific date it is necessary to request it months in advance. We would like a chance to prove we are reliable. It would help us, and you, if requests for publications were addressed to:

Canadian Nurses' Association
74 Stanley Avenue, Ottawa.

Please print your name and address. We will be as dependable as we can in complying with your requests.

All worthwhile achievements are made by men and not by things. All scientific, economic and social accomplishments are rooted in the human quality that produced them. All knowledge, all action, all progress succeeds or fails according to its effect on the human body, mind and spirit. The individual is the indispensable ingredient of business.

If man is an animal then it is efficient to use him, depreciate him, consume him, and discard him; but man is not an animal. No one, no employer, no government, no dictator can trample with impunity upon the human personality.

We must operate in our offices and plants under the promise that we cannot 'use' people, that our associates don't work 'for' us but 'with' us.

Those of us who are privileged to make our living working with people have an obligation to people. Our responsibility to people is a matter of major import.

— WILLIAM E. SCHEER

* * *

Discomfort, embarrassment and expense, not the doctor's warnings of impeding disaster, provide the incentive to slim.

— *Stethoscope*, March, 1960

* * *

Canadian Facts Ltd. has revealed that 81 per cent of Canadians employed in inside jobs have coffee-breaks.

Canadian Nurses' Association

PUBLICATIONS LIST
ORDER FORM

	CHARGE	NUMBER ORDERED
Spotlight On Nursing Education — The Report of the Pilot Project for the Evaluation of Schools of Nursing in Canada	$3.00	
Report of 50th Anniversary General Meeting	2.00	
Public Relations Guide	1.00	
Job Analysis and Job Evaluation	1.00	
Manual for Head Nurses in Hospitals	1.00	
Report of the Canadian Conference on Nursing	.75	
I.C.N. What it is . . . What it does . . . How it works Single copy free (1 dozen)	.50	
Report of the Special Committee to Study the Teaching of Professional Adjustments	.40	
International Code of Nursing Ethics (1 dozen)	.30	
CNA Brief to Royal Commission on the Economic Future of Canada	.30	
Orientation Manual	.25	
Toward Improved Job Satisfaction — A Guide for Employing Agencies	.25	
Nurses, Their Education and Their Role in Health Programs	.10	

FREE PUBLICATIONS

A.B.C. of C.N.A. — Simple Facts and Figures	
A.B.C. of I.C.N.	
C.N.A. Act of Incorporation and By-Laws — amended 1958	
C.N.A. Is Your Association	
C.N.A. The First Fifty Years	
Canadian Nurses' Association Retirement Plan	
Facts and Figures About Nursing in Canada	
Nursing (available from provincial nurses' associations)	
Opportunities for Registered Nurses in the Mental Health Field	
Policies Regarding Nursing Service and Nursing Education	
Report of the Evaluation of the Metropolitan School of Nursing	
Report of the Study of the Functions and Activities of Head Nurses (loan copies only)	
Student Nurses Recruitment Folder	
The Nursing Profession in Canada	
What to Look for When Choosing a School of Nursing	
Will Accreditation Lead the Way to Better Nursing?	

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CUT ALONG THIS LINE

VISITING NURSE

ADELINE KNIGHT CLARK

Kamloops, a community of 18,000 people, is the setting for an experiment in home nursing care. Sponsored and operated by the Irving Clinic, composed of ten doctors, it was instituted in January 1956. An evaluation of this work is attempted from the vantage point of four year's experience.

THE VISITING NURSE serves surgical, medical, pediatric and gynecological departments of the clinic. All home visits are made on the attending doctor's orders. Much is accomplished by this service. It serves the important purpose of maintaining contact between patient and doctor which is more difficult to ensure in home care than when daily hospital rounds are made. When the doctor on call has made a house visit which needs follow-up, he sends the visiting nurse who carries out his orders and brings a report directly to him. This report is important. If progress is satisfactory the patient is saved the expense of an extra visit. However, if the clinical picture indicates progress is not satisfactory, the doctor calls again. In this way, the same doctor handles the case throughout the illness. Symptoms, which the patient often fails to recognize as important, are observed by the nurse and reported. The patient is cheered, reassured, and encouraged by the nurse's visit. The visiting nurse cares for patients until hospital beds are available, a not-infrequent problem. The service is one answer to the critical nursing shortage, because with her help many more people can be cared for in their homes. It often affords health teaching opportunities. Thus the visiting nurse acts as an important liaison between doctor and patient.

The service is not a duplication of the public health program but is a specialized service which strives to perpetuate the doctor-patient relationship so dear to many in the days of the old "family doctor." No fee is charged for the nurse's visit. Her salary and car expenses are paid by the clinic. The usual charge for injections, dressings and laboratory work is made. In this respect the service is self-supporting although at no extra cost to the patient.

A more detailed picture of the work will be illustrated in these two examples:

Medical care: Many elderly shut-ins who are not ambulatory but require injections of various kinds, such as B_{12}, liver, theomerin etc. Some of these patients develop pneumonia which necessitates daily visits, injections of penicillin, temperature, pulse, cough and sputum checks, intake, output and diet. Bed care is also given when no one is available to give the required care. The visit serves a five-fold purpose:

A report to the doctor,
a visit to a lonely shut-in,
the elimination of a tiresome, often expensive journey to the office,
health teaching,
conservation of a hospital bed.

Cardiovascular conditions are treated at home. In such cases the patient avoids the extra strain of dressing and travelling to and from the clinic. The home visit gives closer supervision and observation than is otherwise possible. The patient is able to live in familiar surroundings, enjoy friends and family, yet he may be admitted or readmitted to the hospital if the nurse's visit indicates progress is unfavorable. Electrocardiographs are done in the home as well as necessary blood work and injections. Many patients benefit from the therapeutic effect of being part of the family unit, taking part in plans, discussions, all of which contribute to recovery.

More dramatic care centres around the patient with a coronary thrombosis. First, the doctor arrives and examines

Mrs. Clark, a graduate of the Vancouver General Hospital, is the visiting nurse for this Kamloops, B.C. doctors' clinic.

the patient, then the visiting nurse does the electrocardiograph. The internist interprets the cardiograph and finalizes the diagnosis. The patient is admitted to hospital by ambulance.

Terminal cancer cases often desire to be with their families as long as possible. Thus, semi-weekly bed bath, daily back care, enemata, etc., given by the visiting nurse makes such a wish possible. Sedatives are administered as ordered. Members of the family are taught to help where possible and to adjust to the illness.

Surgical care: The visiting nurse's work includes suture removal, changing dressings, irrigating infected areas and dressing burns. Children, as well as adults, who are unhappy in hospital, benefit from this pattern of adequate home care.

Gynecology and obstetrics: The work includes suture removal, blood work and visits to check progress before and after delivery if a special problem exists.

Pediatrics: Caring for the medical and surgical patients forms a major part of the program. The mother welcomes the visiting nurse. It affords her an opportunity to clear all sorts of problems, to have the child treated at home, to eliminate the necessity of hospital care or office treatment. The watchful, trained eye of the nurse takes back an accurate report to the pediatrician. The mothers, especially the new, young mother who has had a problem with her baby in hospital, is visited until the nurse is sure everything is going well. Many questions are asked about formulae, undetached cords, stools, etc. Premature babies are visited for several weeks.

Dressings and injections are done. Since it is a problem for the mother with a small baby or sick children to visit the clinic, the nurse goes to the home equipped with sterile dressings and the essentials for injections of antibiotics, iron, manganese butyrate, etc.

Children with rheumatic fever are visited regularly. Venous blood is taken, citrated and returned to the laboratory for sedimentation rate. Antibiotics are given, blood pressure checked and, when ordered, electrocardiographs done. Guidance regarding rest habits is given during the visit. Some children are doing their school work by correspondence. They are always interested and anxious for a report of others doing similar work. Projects for handiwork and amusement are discussed and exchanged. Kamloops, being the centre of a ranching country, has many outlying homes. Children from ranch homes are often unhappy in hospital. The nurse has travelled many miles to rheumatic fever patients thus isolated but requiring bed rest.

A Typical Afternoon's Work

1. Mrs. R. is a postoperative nephrectomy with drainage — dressing changed, progress good.

2. Mrs. W., three miles from town at a company development, removal of sutures from hernia repair, incision clean and well healed.

3. Jane, given 1,200,000 units of L.A. penicillin given I/M blood collected for sedimentation rate. A bright child doing Grade VII work by correspondence, Jane discusses her progress with interest.

4. Mrs. M., arthritic on Butazolidin, blood collected for WBC differential, hemoglobin and sedimentation rate and delivered to laboratory technician.

5. Mrs. K., mother of six small children, Bell's Palsy — 2 cc. B Plex I/M.

6. Mr. A., age 70, had collapsed while curling. He had been taken home and put to bed. EKG taken for internist; confirmed coronary thrombosis. Admitted to hospital by ambulance.

7. Mrs. B. with four small children, the eldest diagnosed that morning as scarlet fever. All were given prophylactic injections of all-purpose Bicillin.

8. Constable C. with a history of flu-sinusitis — treated with penicillin. Had allergic reaction to penicillin of the erythemic multi-form type. Blood for WBC and differential was taken. He had a temperature of 102.3° and looked miserable. He was glad to have a service that allowed him to stay in bed at home.

I never wonder to see men wicked, but I often wonder not to see them ashamed. — SWIFT

oral CHLOROMYCETIN Kapseals®—the opaque white capsules with grey band—for unvarying potency, purity, and efficacy from dose to dose • CHLOROMYCETIN Palmitate—for children and adults who prefer a liquid medication—an easy-to-give, easy-to-take custard-flavoured suspension. **parenteral** CHLOROMYCETIN Succinate—so versatile it can be given intramuscularly, intravenously, or subcutaneously.

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ophthalmic CHLOROMYCETIN Ophthalmic Ointment and CHLOROMYCETIN Ophthalmic Solution for notable efficacy...ready penetration into ocular tissues. **topical** CHLOROMYCETIN Cream, 1% for rapid clearing of superficial skin infections and surgical wound infections—all important members of a distinguished family

Since its introduction early in 1949, the unusually broad range of antibacterial action of CHLOROMYCETIN, its purity, outstanding tissue diffusibility, and low incidence of gastrointestinal side effects have combined to make this Parke-Davis antibiotic an agent of choice throughout the years[1-14] in a wide variety of systemic and localized infections.

The numerous dosage forms of CHLOROMYCETIN—designed to meet virtually every type of clinical application—offer the physician the added convenience of flexibility of dosage and administration according to the requirements of the patient.

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(chloramphenicol, Parke-Davis)

Chloramphenicol is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy. Medical literature available on request.

References: (1) Ehrlich, J., *et al.*: *Science* **106**:417, 1947. (2) Woodward, T. E., *et al.*: *Ann. Int. Med.* **29**:131, 1948. (3) Smadel, J. E.: *Am. J. Med.* **7**:671, 1949. (4) Parker, R. T., *et al.*: *J.A.M.A.* **143**:7, 1950. (5) Lewis, R. S., & Gray, J. D.: *Brit. M. J.* **2**:939, 1951. (6) Trice, E. R., & Shafer, J. C.: *J.A.M.A.* **149**:1469, 1952. (7) Robinson, H. M., Jr., *et al.*: *Bull. School Med. Univ. Maryland* **38**:109, 1953. (8) Roper, K. L.: *Industr. Med.* **23**:50, 1954. (9) Costner, A. N.: *South. M. J.* **48**:1192, 1955. (10) Deacon, W. E., *et al.*: *Antibiotic Med.* **2**:143, 1956. (11) Josephson, J. E., & Butler, R. W.: *Canad. M.A.J.* **77**:567, 1957. (12) Blair, J. E., & Carr, M.: *J.A.M.A.* **166**:1192, 1958. (13) Goodier, T. E. W., & Perry, W. R.: *Lancet* **1**:356, 1959. (14) Rebhan, A. W., & Edwards, H. E.: *Canad. M.A.J.* **82**:513, 1960.

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NURSING PROFILES

The appointment of **Muriel McArthur** as matron-in-chief of the Canadian Forces Medical Service became effective late last summer. A graduate of the Toronto General Hospital, Miss McArthur has been a nursing sister with the Royal Canadian Air Force since 1941.

During World War II she served in England for a two-year period. She has served as matron of the RCAF hospitals at Goose Bay, Labrador and Rockliffe, Ont. For three years, 1954-57 she was stationed in Metz, France as matron with No. 1 Air Division. For several months prior to her present appointment she was a member of the Surgeon General's staff, Canadian Forces Medical Service.

MURIEL MCARTHUR

Miss McArthur has achieved the rank of squadron leader, RCAF. An appointment as Queen's honorary nursing sister in 1958, was repeated in 1959. She is succeeding Miss Mary Nesbitt as matron-in-chief. Miss Nesbitt proceeded on retirement leave early in September 1960 after a distinguished career with the Royal Canadian Navy.

Dorothy Monteith has been appointed to the Ontario Hospital Services Commission as a nursing consultant. This raises to four the complement of nurses on the staff of the Commission.

A native of Saskatchewan, Miss Monteith

DOROTHY MONTEITH

is a graduate of Guelph General Hospital. She has had considerable experience in nursing administration, including two years as director of nursing, Sudbury Memorial Hospital and, recently, a period as assistant director of nursing, Guelph General Hospital. Prior to this she had spent several years in the United States as operating room supervisor, Presbyterian Hospital, Chicago and later at Peter Bent Brigham Hospital, Boston. She had taken special preparation in operating room technique and management at the New York Postgraduate Medical School. During 1954-55 she had also served as consultant in operating room, obstetrical and central supply services to the Memorial Hospital Association of Kentucky, Washington, D.C.

Kathleen Florence Brady has become the assistant director, Montreal Branch, Victorian Order of Nurses. Her experience with the Order dates back to 1953 when she began work as a staff nurse, succeeding to the position of supervisor of the west district, Greater Montreal, in 1956.

A graduate of St. Mary's Hospital, Montreal she has had extensive postgraduate preparation. In 1951 she completed requirements for her bachelor's degree in nursing from McGill University majoring in administration. In 1955 she obtained her Master of Arts from Teachers College, Columbia University where she specialized in super-

KATHLEEN BRADY

vision in public health nursing. In addition she has had special study in operating room techniques and psychiatric nursing.

Following some years of experience as an operating room nurse and as an occupational health nurse with Canadian Car Munitions, Miss Brady served overseas in World War II as a nursing sister, 1943-45. She engaged in private nursing for two years after her return to civilian life before becoming assistant director of nursing, Verdun Protestant Hospital. Her administrative ability, her experience in a variety of fields of nursing, and her already extensive service within the Order have been excellent preparation for her present role.

(Jac-Guy)

SISTER MARGUERITE DU SACRÉ COEUR

Sister Marguerite du Sacré-Coeur was appointed director of nursing, Notre Dame de l'Espérance Hospital, Montreal during 1960. A 1955 graduate of this same hospital, Sister holds her bachelor's degree from Institut Marguerite d'Youville where she majored in nursing education. Her excellence as a student merited her special mention from the Institute.

Prior to her present appointment, Sister served as night superintendent and as charge nurse in the emergency room and dispensary of her hospital. Leisure time is almost an unknown quantity, but when she has a few spare moments she enjoys music, reading, and singing. She has a particularly keen interest in research — a most valuable quality for her present position.

Serving in the dual capacity of director of the school of nursing and assistant director of education, Notre Dame Hospital, Montreal is **Sister Claire Jeannotte.**

SISTER CLAIRE JEANNOTTE

A graduate of Hôpital Saint-Jean, St. Johns, P.Q., Sister holds her B.Sc.N. from Institut Marguerite d'Youville, Montreal and has had further study at Teachers College, Columbia University. She comes to her present position with broad general experience acquired in a number of Canadian hospitals. Shortly after graduation she joined the staff of Notre Dame Hospital, Montreal as a head nurse, and remained for several years before going on to the Edmonton General Hospital. A year's service there was succeeded by an equal period as assistant director of the school of nursing,

St. Paul's Hospital, Saskatoon. An additional two years in the same institution was spent in head nurse duties. She returned to Montreal in 1954 to act as educational coordinator in her present hospital.

NANCY FRANKLIN

The Children's Hospital of Winnipeg welcomed its new director of nursing, **Nancy R. Franklin,** during 1960. Born in England and a graduate of the Hospital for Sick Children, Great Ormond Street, London, and of Addenbrookes Hospital, Cambridge, England, Mrs. Franklin first joined the staff of the Montreal Children's Hospital in 1948. For the past 12 years she has been a valued staff member of that hospital as a supervisor, clinical teacher and latterly as administrative assistant.

She is a graduate of the McGill School for Graduate Nurses where she obtained her diploma in teaching and supervision in 1953. When she left Montreal to take up her new duties, a number of organizations lost a willing and able member. She was vice-president of the local nursing instructors' group and held the same office in the alumnae association of the McGill School for Graduate Nurses. With a young son to bring up, she had also taken an active interest in Home and School Association work as well as in the activities of Cubs and Boy Scouts.

Every good wish is extended to her for success and happiness in the future.

Evelyn M. Pibus, whose association with the Victorian Order of Nurses has extended over 32 years, has retired from her position as assistant district director, Greater Montreal branch. Her service with the Order has been varied. She began as a staff nurse and later as nurse-in-charge of the branch at Carleton Place, Ont. Then she became supervisor of the east district, and finally of the north district, Greater Montreal Branch. This was succeeded by a period as a regional director.

(Wm. Notman & Son)

EVELYN PIBUS

A graduate of Montreal General Hospital, she has made an outstanding contribution to public health nursing. She has given freely of her spare time to various professional organizations. Miss Pibus will be greatly missed by her VON colleagues and by her community.

Voice of Women was formed to unite the women of Canada and ultimately, the women of the world in an effort to find peaceful solutions to the world's problems. It is a communications project planned by women experienced in international affairs, and in the mass communications fields of radio, television and the press.

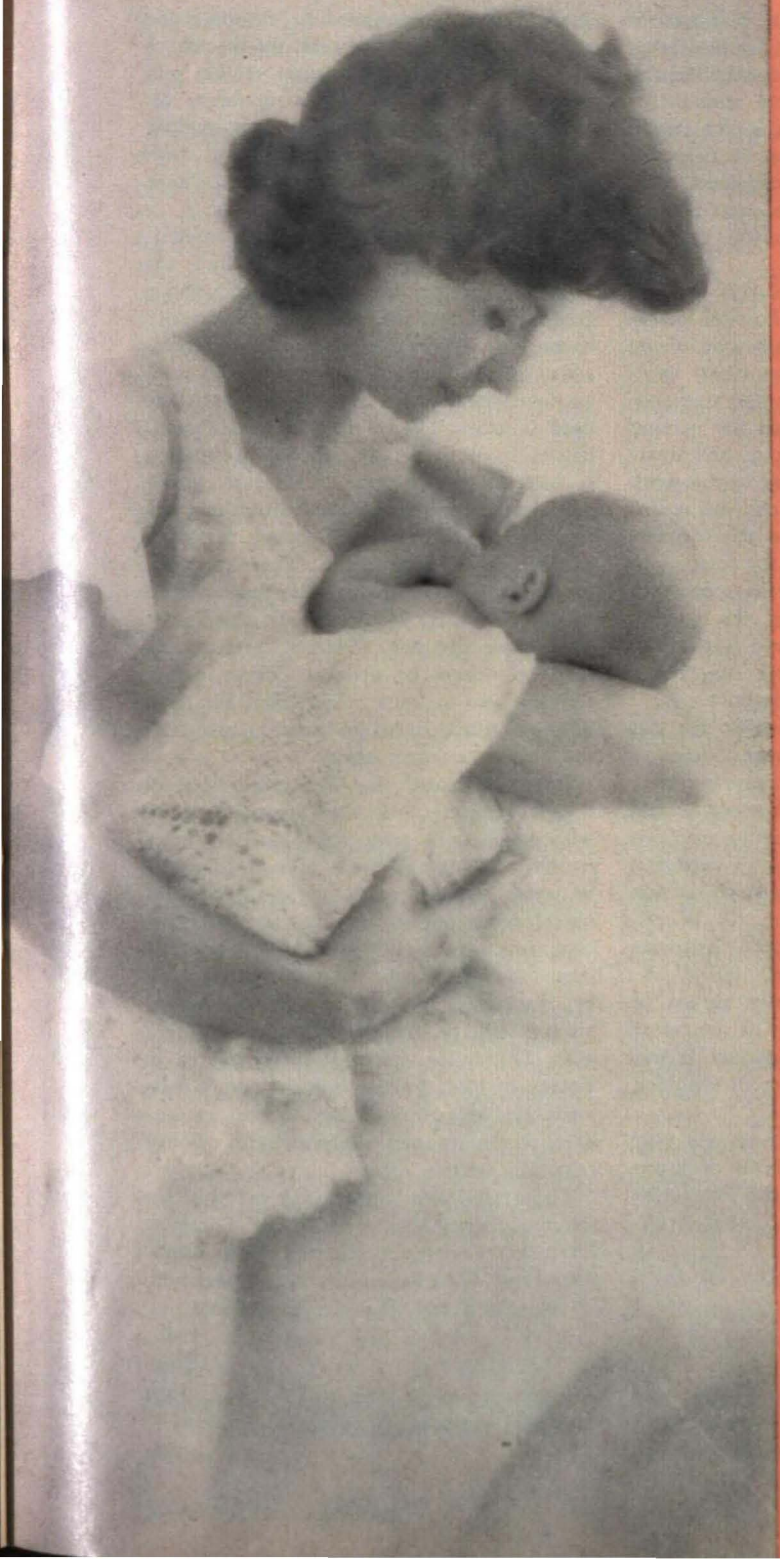
You can help to prevent nuclear war by supporting VOW. Write: Room 204, 329 Bloor St. W., Toronto, Ontario.

* * *

The reason why so few people are agreeable in conversation is that each is thinking more of what he is intending to say than of what others are saying; and we never listen when we are planning to speak.

—ROCHEFOUCAULD

AS WITH MOTHER'S MILK . . .



As with mother's milk, S-M-A (Food formula for infants, Wyeth) provides proteins, carbohydrates, vitamins and minerals to meet the known nutritional needs of the human infant. S-M-A compares closely with human milk in percentages of protein, fat, milk sugar and ash

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WALKERVILLE, ONTARIO

AN EXTENSION COURSE IN NURSING UNIT ADMINISTRATION

KATHLEEN RUANE

FOR SOME YEARS, the acute shortage of nursing personnel qualified for leadership positions has been of great concern to the nursing profession, to hospital administrators, and to other disciplines in the health team. To those in the hospital field the lack of nurses, skilled in management techniques, has been one of the most serious drawbacks in the effort to improve the care of patients.

The rapidly growing population and the introduction of compulsory hospital insurance plans have caused an expansion of the nation's hospital services. The rising number of admissions to hospitals has been continually increasing the demand for nursing service. Changes in medical care and treatment have added responsibility to the work of the nurse. She must not only be skilled in nursing practice but also be able to guide others in their work. While the total number of nurses graduating from schools of nursing has been increasing, the number who have the kind of specialized preparation needed for administrative and supervisory positions has not gone up proportionately.

Recognizing that many nurses are not prepared for head nurse responsibilities, a joint committee composed of representatives from the Canadian Nurses' Association and the Canadian Hospital Association met two years ago. The desirability of an extension course for head nurses and supervisors was discussed and a proposal to the W. K. Kellogg Foundation for financial assistance was formulated. In July, 1960, the W. K. Kellogg Foundation generously agreed to provide financial support for a four-year period and the project was launched. It was called the Extension Course in Nursing Unit Administration.

Tentatively, the course will be one year in length. It will take the form of intramural and extramural sessions. The intramural phase will involve an initial workshop or seminar designed to introduce the students to the objectives and the mechanics of the course. The extramural section will consist of home study and assignments related to the work situation. A final seminar will be scheduled to deal in depth with some of the subjects covered in the home study lessons.

The extension program in ward administration is not offered as a substitute for university preparation, nor will it provide credits that may be applied to university courses. It is designed to improve professional performance on the job and to meet an immediate need in an area where the need is great. The number of nurses graduating from university schools of nursing is increasing each year. They are giving splendid leadership in many institutions and agencies but there are not enough to fill all of the positions available. There are approximately 7000 head nurses in hospitals in Canada today. Many are not able to attend university for advanced preparation, for one reason or another. These nurses feel the need to know more about the techniques of management, in order to cope with the complex ward situation.

It is anticipated that the preparation of lesson material and the organization of workshops will take approximately nine months. During this time, pilot lessons will be tested and revised by various groups of nurses and administrators to ensure that assignments are sound and practical. The course will be ready to go into operation by September, 1961. The selection of applicants will be completed by June of that year. The entire course is to be offered in French in 1962. Further information will be made available through the *Journal* as progress continues and decisions are reached regarding certain details.

Those who are interested in enrolling for the course should write to: Director, Extension Course in Nursing Unit Administration, Canadian Hospital Association, 25 Imperial Street, Toronto 7, Ontario.

Miss Ruane is the director of the course that she has described in this article.

Learn from the mistakes of others. You haven't time to make them all yourself.

— BERTRAND RUSSELL

Great God, I ask thee for no meaner pelf
Than that I may not disappoint myself.

— THOREAU

The Role of the Nursing Assistant in a Modern Hospital

ROGER B. GOYETTE, M.D., D.P.H.

The career of the nursing assistant was born out of a need to assure complete patient care according to a rational method that would permit hospitals to function with a maximum of efficiency.

ALTHOUGH NURSING assistants have existed for some time, they have now been accorded official status by the Association of Nurses of the Province of Quebec. The ANPQ assisted in the creation of schools through the development of a curriculum and continues to evaluate and approve schools for this group that is so closely associated with the nursing profession. Certification of nursing assistants by the ANPQ is proof that the nursing profession in this province takes an active interest in patients' problems and needs through development of the service it offers to the public.

The economic development of our country has created a variety of problems of which hospital administration has its share. One of these problems concerns hospital personnel. Thanks to the discoveries of modern science the patient stay in hospital is much shorter than it was 20 years ago. It is so short, in fact, that it poses problems to be resolved in the interest of patients from the standpoint of the needs of the personnel.

In 1945, at the request of the Canadian Nurses' Association, the federal government undertook a study of the needs of hospitals for auxiliary personnel. At that time it was recognized that, if hospitals were to adequately carry out their task, creation of auxiliary nursing personnel was an urgent necessity. The CNA expressed concern that in spite of world wide efforts to recall graduate nurses to active duty, and the increased enrolment in schools of nursing, there were not enough qualified nurses to meet the demand. In Canada, the number of graduate nurses has increased from 33,000 in 1945 to more than 60,000 today. This considerable increase still does not meet the demand. Although schools of nursing have active recruitment programs, it is evident that growth in population, progress in industrial hygiene, the increase in the number of medical specialties, new techniques, and an increase in the number and size of hospitals are factors in the inability of schools to meet the demand for more graduate nurses.

The doctor, burdened with work that is increasingly exacting, has delegated many of his former tasks to nurses. The nurse now teaches patients, takes blood pressure, changes dressings, administers intravenous solutions, collects specimens, uses complicated therapeutic equipment, observes and controls reactions of patients, and has numerous other responsibilities formerly considered purely medical.

With the advent of hospitalization insurance, the activities of nurses have been anything but simplified. Directors of nursing have been talking for a number of years of the problems they have to face and have complained of the lack of competent personnel. Modern nursing care demands the utilization of auxiliary nursing personnel, in order to take advantage of the maximum resources of professional nurses.

These circumstances have necessitated an accurate analysis of nursing activities in order to determine what hospital administration could expect of various categories of workers. It was necessary to determine the knowledge required by each group so that each might make its appropriate contribution to the care of the sick. These studies indicated the necessity of or-

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ganizing a work team. This system, already found practical in many hospitals, synthesizes the contributions of a group to simulate the individualized care that was given in most hospitals some years ago.

In the team approach to patient care the nursing assistant has an essential role. She is given the responsibility of carefully performing certain basic tasks. By collaboration, professional nurses, certified nursing assistants and other trained persons can organize and give integrated care to patients. The nursing assistant must always remember that her part of the care is a shared responsibility and has an effect on the patient's welfare. It is understood that the team includes the attending physician and that the work assigned to the team carries with it some medical responsibility by delegation. Under the physician is an ordered hierarchy composed of the head nurse, team leader, student nurses and nursing assistants.

Formerly, a graduate nurse was solely responsible for the nursing care of five or six patients. Now, with the help of two or three nursing assistants, there may be as many as fifteen patients under the care of the team leader. Under the former method of assignment these fifteen patients would have required the services of three nurses and two aides. This modern system makes patient care more costly. From the first appearance of the nursing assistant on the scene, she has been a team member who shared responsibility with the physician and professional personnel. Sharing responsibility does not diminish her personal responsibility for the contribution that she makes to total care.

Each day when the team leader assigns particular tasks to a team member, that person is individually responsible for the service she renders and for which the patient is paying. Each is accountable for the accomplishment of an essential social obligation. The care the nursing assistant gives, such as meeting the personal hygiene needs of her patients, and the maintenance work that she does has a direct bearing on the welfare of the patient and are important. When she assists the doctor or the nurse, she must be absolutely discreet with patients, visitors, parents, friends and others with whom she comes in contact. The professional secrecy which applies to doctors and nurses applies equally to the nursing assistant. This discretion is a trust of honor and is the patient's rightful due.

The nursing assistant can fulfill another function for which her training prepares her to a greater or lesser degree depending on the benefit she derives from her experience with hospitalized patients. It is not easy to give care at home, even under the direction and supervision of a graduate nurse, when the situation is exacting and one has not derived maximum benefit from hospital experience. This is the reason that some schools for nursing assistants require their graduates to spend six months gaining practical experience following their planned course of theory and the year of practical demonstration.

The certificate is, therefore, a valuable document. It is official recognition of the competence of the nursing assistant, by the medical and nursing professions. The nursing assistant occupies a definite and official place among those who serve the public in the field of health. In order that the contribution of the nursing assistant may be used to best advantage, that her service may bear fruit that will benefit society, it is important that her qualifications and the precise limits of the care she may give are clearly understood by all.

Whether the nursing assistant serves in a hospital or in a home, her work is part of that performed by a profession which is essential to the welfare of society. When she gives the best care of which she is capable, with unselfish devotion, she is a credit to herself and to the profession as a whole.

Because of the daily demand for more nursing assistants in hospitals, it is probable that more will remain in hospitals where the work is varied and further experience is available. Their presence in the nursing team enables the hospital to give better care to a larger number of patients, to take advantage of the particular abilities of all hospital personnel, to delegate more responsibility to the general duty nurse and to promote greater satisfaction

among all the team's members.

In general, the acceptance of the nursing assistant into the family of nursing service personnel is an accomplished fact. There is no longer a question of the efficacy of returning to methods of the past that are now inadequate. It would be wise, however, to continue to analyze nursing functions, to assist the nursing assistant to become even more efficient, while maintaining a rigid line between the tasks that the nurse performs and those that she can delegate.

The new method has not only been accepted by nursing service and hospital administration. Patients are satisfied to find that, with the team approach, the care they receive is of a high quality and includes details which to them are important.

The nursing assistants' curriculum, as prepared and controlled by the ANPQ, has already produced excellent results. Its inauguration has been justified, because it responds to the needs of our century and the demands made by progress.

If the nursing assistant is to have a successful career, there is more involved than an ability to follow directions. Love for her patients, as they are, and devotion are essential characteristics of those whose knowledge and skill converge in close personal contact with people.

A NURSE'S HOME

JEAN E. SHERWIN

With all the extras and luxuries in the nurses' homes of today, are the students any happier than the students of 25 years ago?

IT WAS A WARM SEPTEMBER afternoon when we were ushered, one by one, depending on our time of arrival, into the "Home" — that "Home" that was to be ours for the next three years. We were student nurses and that day in the year 1935 began for us a part of our lives that could never be forgotten. We stepped into the small, dark vestibule of the Nurse's Residence of the Royal Alexandra Hospital, Edmonton, and waited for the "doorkeeper." In a sweet, shrill voice she welcomed us — or was it a welcome?

> Take your bags to the fourth floor. Your name will be on one of the doors. Report back to the reception room, in uniform, at five o'clock.

This same greeting, in probably the same tone, was repeated 35 times that day as thirty-five anxious young ladies staggered up those stairs carrying bags and boxes of many descriptions, to find their special floor.

Down the corridor with its squeaky, highly polished floors we scanned each door with its small white name card to find our room. Some showed three names to a room, others had four. A small window with its white, starched muslin curtain, hospital-sized beds, freshly made with snowy white bedspread, dressers, desks and chairs for each student, were what met our eyes as we ventured to open that door that had been labeled with our name.

At the appointed time, in our first uniforms, we made our way to the main floor reception room. It was lovely and home-like, typically furnished with several over-stuffed chesterfields and chairs of drab greys and browns, oriental designed rugs scattered on highly polished floors, the radiant fireplace with its high mantle, a few lamp tables, and a piano. Here we assembled to hear those first basic rules.

Rising bell at 6:00 A.M. — on duty at 7:00 A.M. — to be in residence at 10:00 P.M. each night — monitor rounds and lights out at 10:30 P.M. Four late leaves until midnight were granted each month. The penalty for

Mrs. Sherwin resides in Edmonton, Alta.

any offence was to forfeit one or more of these treasured late nights. Each day, our rooms were to be left neat and tidy, ready for inspection. A hair-net was a compulsory part of our uniform.

Here in this reception room, each morning or evening, we gathered like a family for prayers and to hear the new orders for our stations of duty. Then we marched two by two, in order of class and seniority, to the hospital, there to disperse as our destinations were reached. Like a regiment, we "learners" set off each day.

Our off-duty hours were spent back in the "Home" and it seemed the bathrooms were the appointed place. In these rooms, neat and clean with slab grey walls were hung, somewhat precariously, several white enameled sinks. These were our laundry, shampoo, snack and even music (singing in the bath-tub) rooms. With a mouthful of toothpaste we could exclaim over a new dress, or shriek as the message came that our date was waiting. Here we read those letters from home to other classmates as they worked over a wash basin.

Much of our time for learning was spent in the classroom where we were certain to find Mrs. Chase, the life-sized model used to demonstrate and practise treatments. She couldn't talk back or groan at our clumsy procedures. She remained still, quiet, and content.

We were a happy lot — that is, for most of the time. When waves of homesickness or frustrations came upon us, we would gather, like sardines in a can, in one room. The wise one of the class would counsel, the clown would have us laughing through our tears, the others were there to add comfort and friendship.

Without elevators, inter-communication systems, music rooms, hair dryers, automatic washers and dryers, beau rooms and shorter working hours, we made a life for ourselves filled with memories and friendships that have lasted through the years. We saw much of living and dying, and spent much time in service to the ill and infirm.

This week many of that same class of 25 years ago strolled through the new Nurse's Home of the Royal Alexandra Hospital. A beautiful and delightful monument to a glorious profession, it is the latest thing in design and structure, ultra-modern in style and color.

In the spacious rotunda, the expanse broken by large terrazo-tiled columns all in rich shades of variegated colors, we stepped over to see the intricate system by which each student could be contacted in her room or in any of the other rooms provided for leisure time.

The smooth, quiet elevators took us to one of the many floors to see a typical, bed-sitting room. The rooms were identical except for color, with a large window, beautifully draped, a built-in dressing table complete with sink and mirror, ample drawer and cupboard space, a settee appropriately covered, that pulled out from the wall to make a comfortable bed. In all, 380 of these rooms could house each student individually.

Back down the carpeted corridors we passed to return to the reception room on the main floor. This spacious expanse, surrounded by brick planters and one full wall of draped windows, was beautifully furnished. The lounges and chairs in solid colors of deep purple, mauve, turquoise, and robin's-egg blue grouped artistically on rich, deep-piled rugs of olive green, together with scattered coffee tables, an open stone fireplace and grand piano, made it complete and inviting.

Moving on down the hallway we looked in on one of the several beau-rooms especially designed for those "callers" in need of quiet and privacy. On and through large double doors we came upon the chapel, made solemn and restful with delicate, indirect lighting, its stately pews and altar so needful in that busy life for a quiet time and prayer.

In the large and abundantly equipped instruction rooms we were happy to see Mrs. Chase again (though not likely of the same generation we had used) and too, our friend Oscar, the skeleton in the closet. One feature of these rooms was a large revolving platform, complete with bed and other equipment, which meant that demonstrations could easily be seen by all students.

Downstairs were the recreation rooms, the TV and music rooms. Here,

too, was a laundry with its many washers, dryers and ironing facilities. The shampoo room that would be a delight to any beauty parlor, with special sinks and tilt-back chairs, several hair dryers all done up in bright color of deep coral, made hair grooming so pleasant and easy. Also to be found there was a special sewing accommodation, a very complete kitchen and a tuck shop.

As we strolled through these luxurious places, memories of that old residence flooded back. With all this, could these girls be a happier, livelier group than we had been? So much had been added, yet so much remained the same. To be well-adjusted, to forget self, to have that deep compassion in the careful handling of mind and body of the persons entrusted to our care; to be scrupulously clean, well-groomed in stiffly starched apron, bib, and cap over the basic blue uniform, this had never changed. Our rigidly controlled curfew had become flexible, sleeping out permission with days off gave a welcome change. Much had been added to the training to keep pace with the strides achieved in medicine and science.

Yes, with all the vastness and luxury, the planning for recreation, snacktime and cosmetic culture, these girls of 1960 and future classes will find each other. To laugh, to cry, to borrow, to lend, to thrill or show concern — that off-duty pattern will see little difference.

Today the trend for all is a convenient, comfortable way of life with much interest in entertainment for leisure time. Who are more deserving than our "Ladies with the Lamps?"

GROUP ACTION

VICTORIA ANTONINI, B.N.

A summary of the 3rd Annual Institute for the professional staff of Provincial and National Nurses' Organizations.

OTTAWA IN AUTUMN. A walnut-panelled board room in the new edifice of the Royal College of Physicians and Surgeons of Canada was the setting for the Third Annual Institute for the professional staff of provincial and national nurses' organizations held September 26-30, 1960. Miss F. Lillian Campion, nursing secretary, CNA was chairman. Represented at the institute were the Canadian Nurses' Association and the provincial nurses' associations with the exception of Prince Edward Island.

A welcome participant was Miss Margaret Stewart, executive secretary, Royal College of Nursing, Scottish Branch, who was visiting in Canada and the United States to observe the activities in provincial and state associations.

Miss Antonini is the executive secretary of the Saskatchewan Registered Nurses' Association, Regina, Sask.

Topics presented were: Counselling and Guidance, Office Administration and Employment Relations. An evaluation report of the previous day's activities was submitted daily by three members of the group.

A registration and coffee hour Monday morning, gave the members the opportunity to renew acquaintances, and set an atmosphere which continued throughout the institute — relaxed, friendly and conducive to the active participation of all who attended.

Following a welcome from Miss P. Stiver, general secretary, CNA, the program for the first two days, "Counselling and Guidance," was under the direction of Dr. Thomas J. Mallison, clinical teacher, Department of Psychiatry, University of Toronto. In his introduction, the speaker stated that in today's "group society," individuals have closer relationships with one another. One of the greatest problems in hospitals and industry arises be-

cause people are working together yet the administration of human relations remains haphazard.

When a group meets, each member will study any problem in relation to his own individual needs and goals. This was demonstrated in a film, "Meeting in Session," in which a group of nurses tried, unsuccessfully, to suggest a solution for a specific problem. It was evident that the meeting accomplished nothing because of an ineffective leader who failed to adequately identify the problem and purpose of the meeting; lack of understanding and communication in relationships; and the projection of individual needs and goals.

Dr. Mallison indicated that any group must have a goal that is carefully identified in order for people to work together for its achievement. It is necessary to be aware that there are two levels of relationships whenever a group meets. There are those which are concerned with the task or occupation — the public goal; those which are concerned with preoccupations — the individual's goal. Everyone goes to a meeting with an "active set" — a frame of references which each person has in his head. When these overlap, there is communication. When they do not overlap there is no communication.

As relationships between individuals involve communication, considerable time was spent on the value of communication. Members participated in an experiment which demonstrated that complete or partial restriction or distortion of communication can have profound and even devastating effects on the ability of the individual to follow instructions or to solve a problem.

Communication and the movement of the group towards a goal is facilitated through effective "leadering." The leader must be aware of the factors which effect communication, which are:

Individual needs,
status and prestige,
age, sex, social and occupational differences,
clarity of the task,
opportunity for checking perceptions,
size of group,
climate of group.

Leadering may be of four different types:

Autocratic — leader assumes all aspects of responsibility.
leaderless — chaos
democratic, shared — all participants take equal responsibility.
democratic, assigned — each member takes a definite role.

Leadering involves initiating, regulating, informing, supporting, evaluating. We were formed into groups and given role-playing situations. Each person had the opportunity to enact the role of leader and group members while an observer evaluated each performance.

On Tuesday morning, Dr. Mallison discussed the background factors which must be considered by the leader, the factors which may block the satisfaction of the needs of the group members and the release mechanism which is necessary if needs are to be satisfied.

Groups were formed at the afternoon session to identify problems confronting the professional staff in provincial offices. Once these problems were identified, a role-playing situation was set up and enacted.

Under the direction of Mr. Alan Clarke, Wednesday and Thursday were spent considering office administration. The guest speaker, Wednesday was Miss N. Audry Gray, officer, Management Consultant Services, Civil Service Commission, Ottawa, who outlined the principles of office management:

1. *Unity of command* — all action toward the accomplishment of a given objective must be directed and controlled by one individual. Thus, each person should have one immediate superior and should know to whom and for whom he is responsible.

2. *Span of Control* — the number of people a supervisor can control efficiently must be based on his span of attention, the responsibility of his subordinates, his area of supervision and the amount of time available for supervision. There is a limit to the number of subordinates one supervisor can direct effectively.

3. *Rational assignment* — the functions of the workers should be specific, not overlap and should be within the range of safe work load.

4. *Delegation of authority* — individuals must be given the necessary authority to carry out assigned responsibilities.

At the afternoon session Mr. Clarke concentrated on the activities in national and provincial offices in order to outline the problem areas, which proved to be:

1. Uniqueness of position of professional staff, i.e. employer and employee,
2. filing,
3. work output,
4. deployment,
5. handling of periodicals and other references,
6. staff and committee meetings,
7. layout and equipment.

On Thursday morning groups were formed to discuss specific problems to be presented to Miss Gray at the afternoon session. The areas selected and presented for discussion and advice were: work output, filing, deployment, and equipment and layout.

Following a delicious buffet supper served at the College, the members attended an evening session of films — "It's People That Count" and "A Day in the Night of Jonathan Mole" — followed by a discussion period.

Friday's session on employment relations, under the direction of Mr. Clarke, commenced with each executive secretary outlining her provincial association's activities in the field of employment relations. Present for the entire day was a panel of experts in employment relations. Members of the panel who participed actively in discussion and answered questions raised by the group were:

Mr. J. H. Leroux — Executive Secretary, Professional Institute of Public Service of Canada

Mr. H. S. Crowe — Director, Research Department, Canadian Brotherhood of Railway, Transport and General Workers

Miss Evelyn Hood — Director of Personnel Services, RNABC

Mrs. Mary Strong — Nursing Consultant, Personnel Relations, RNAO.

In reference to collective bargaining, Mr. Leroux said that representatives of two bodies with interests somewhat at variance meet together to try to arrive at agreements of employment. Professional people object to collective bargaining because of fear of losing their freedom. The fact that more professional people are employed rather than being self-employed tends to split the profession — some are employees, some employers. Negotiation is based on the fundamental principles of: payment of comparable salaries, as in other industries, and relatively — fairly comparable policies for people with comparable positions and responsibilities.

All were in agreement that the salaries of nurses were low in relation to those of others with comparable positions and responsibilities. Concern was expressed that this would jeopardize the status and prestige of the nursing profession and recruitment. It was pointed out that nursing associations should be negotiating for their members. In summary, Mr. Leroux outlined the principles of negotiation:

1. Collect factual and accurate information — eliminate emotional reasoning,
2. analyze grievances and pin-point problem areas,
3. recommend how problems may be corrected.

Professor Crowe stressed that in preparing for negotiation the following were necessary:

1. Research,
2. group action through the national body,
3. set a standard which can be worked out,
4. learn techniques of negotiating and bargaining,
5. strong management leadership in the nursing profession.

Evaluation

Evaluation of the program on "counselling and guidance" indicated approval of the methods used to impart knowledge. Through excellent use of formal lectures, film, demonstration and discussion, principles were learned which may be applied in dealing with situations requiring counselling and guidance. Individual participation in role-playing situations helped to develop confidence in one's ability to make use of these principles.

The evaluators of "office administration" expressed the opinion of the group when they reported that it was difficult to absorb the wealth of information included in Miss Gray's introduction. Appreciation was extended for the notes which were made available, the practical answers to questions, and the useful references recommended. Although it was felt that

more time could have been spent on this subject it was questioned whether it is possible to receive solutions to specific problems at an institute. It was suggested that "it might be more effective for the National Association to secure a consultant who could visit each provincial office and make suggestions about improving our techniques."

The review of the provincial associations' activities in employment relations initiated discussion which continued throughout the last day of the institute and ended with a summary of principles of negotiating.

The final evaluation applauded the skill of Mr. Clarke, Dr. Mallison, Mr. Leroux and Mr. Crowe in stimulating the group to think and to actively participate in all discussions.

Gratitude was expressed to the staff of National Office for the planning, preparation and conduct of the Institute.

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IDIOPATHIC STEATORRHEA

FANNY HONIG

Sprue, is perhaps a more familiar name for this condition that is characterized by the spontaneous occurrence of fatty stools, hence the use of the term idiopathic.

GINA, A TIMID 19-year-old Italian girl, arrived in Canada about five years ago. She was pretty, average height, intelligent and cooperative. Her chief problem in adjusting to her new surroundings has been language. She lived with her parents, three brothers and two sisters. The children ranged in age from six months to 17 years. Her father worked as a welder and earned $50 weekly, while Gina earned $36 per week. Together, their wages supported the eight members of the family.

Gina's education had been very limited as a result of her physical condition. She managed to complete grade six, but a recurrence of her illness compelled her to discontinue school for a year. At that particular time, although she was 15, she did not appear more than eight years of age due to the gross retardation of her physical development. She remained at home for several months. Then she set out in search of a job and she has worked ever since. She enjoys her work very much but regrets that she was unable to complete her schooling. This appears to be an impossibility partly for financial reasons and partly due to her language difficulty. The latter problem required her to spend longer and harder hours at her lessons than the average student. To resume study might result in too great a strain and lead to another recurrence of illness.

During her latest hospitalization Gina was visited daily by her family, usually in the evenings. She spent the

Miss Honig received her training at the Jewish General Hospital, Montreal.

day reading or chatting with other patients. She never complained and was always ready to cooperate in any procedure directed towards her welfare.

Family History

Gina's mother has been a diabetic for a number of years, and attends the outpatient clinic regularly. Her father, brothers and sisters are all well. There is no history of hypertension, cardiovascular or renal disease, allergy, rheumatic fever or tuberculosis in the family.

Medical History

Gina had suffered a skull injury in her childhood, but no specific details could be obtained about this incident. Her present condition was first detected when she was three years old. Its most obvious effect had been a very severe physical retardation. While visiting relatives in Philadelphia several years ago, Gina's appearance aroused much concern and apprehension in her uncle who immediately took her to a local hospital for investigation. She was treated for hypopituitarism, until she had to return home. She has been under observation in the outpatient department of this hospital since that time.

Six years ago, Gina was admitted with a diagnosis of "idiopathic steatorrhea." She was suffering from intermittent periods of diarrhea accompanied by anorexia. These episodes lasted two to three months, then receded for a similar length of time. During acute phases, the mere sight of food would induce vomiting. Gina ate very little during periods of exacerbation. These flare-ups would disappear gradually with the use of drugs, but never spontaneously. During remissions her weight would be restored, but physical growth was retarded. The onset of menstrual periods was also delayed.

Mentally, she was bright, alert, with an intelligence quotient in keeping with her age level. She had been treated with a high-protein, low-fat diet supplemented by vitamin and mineral tablets. She had also received potassium chloride, calcium lactate, folic acid, calcium gluconate, ACTH and other hormones. These compounds accelerated her physical and secondary sexual development. This treatment continued until she returned to hospital on this particular occasion with symptoms similar to those of previous admissions. Her diagnosis was unchanged. She complained of crampy distress in the epigastric region and subcostal area, radiating to the midaxillary line and occurring before and after meals. This time the episodes subsided spontaneously, but no relief was derived from drugs or medications. Since her previous admission three years before, Gina had grown five inches. Vitamins, minerals and hormones were continued as a part of therapy.

On her present admission, Gina appeared her stated age (19 years) as a result of drug therapy although her breasts and genitalia were still infantile. A normal menstrual cycle had developed in the past year.

Steatorrhea or sprue is the passage of frequent, fatty bowel movements, over a prolonged period of time giving rise to secondary nutritional defects. Idiopathic merely means that the illness is of unknown origin. Sprue is characterized by fatty stools, tetany, osteomalacia, anemia, and a disturbance in calcium metabolism.

Because of its occurrence in patients with pancreatic duct obstruction, atrophy of the pancreas, or absence of pancreatic enzymes, this organ has been carefully studied in relation to the condition. However, there has been no proof of its involvement. In a great many instances, the administration of large amounts of pancreatic juice has resulted in marked clinical improvement. Thus the pancreas is still suspect and its function is investigated when steatorrhea is diagnosed.

When fat digestion and absorption are defective, calcium forms insoluble soaps with fatty acids and is lost in the stool. There is a loss of vitamin D and this contributes to the inefficiency of calcium absorption as well. Vitamin D increases the absorption of calcium from the intestines, but the mechanisms of this process are unknown. A defect in Vitamin B_{12} absorption is also present in the malabsorption syndrome. The main food source of vitamin B_{12} is animal protein, mainly liver. Absorption of this vitamin occurs almost exclusively in the

small intestine. A small amount of it is eliminated in the urine. Feces may contain a considerable amount.

Diarrhea may produce clinical signs of electrolyte depletion. The normal person excretes about 100-200 ml. of water per day in the stool, 2.5 mEq. of sodium and 10-15 mEq. of potassium. In patients with sprue there is an increased fecal excretion of potassium, even in formed stool when the water content is less then 250 ml. per day. The reason for this is not apparent. Many patients show an upset in urinary excretion with a marked noctural polyuria.

Frequently the patient is abnormally pigmented, has a low blood pressure and asthenia. Weight loss is the most common symptom. Unless there is an adequate store of potassium, it is difficult for the patient to regain normal weight.

The major pathological alterations in sprue are to be found in the small intestine. It is not clear as yet whether these changes are due to a specific, local, enzymatic or nutritional defect, or whether they are the results of toxic degeneration or other influences.

Gina gave a history of continued episodes of four to five loose bowel movements daily. These were bulky and foul-smelling. Although she had followed her gluten-free diet very carefully, she had lost 15 pounds in the past seven months.

Still more recently she had developed ankle edema. It occurred in the evening, but was absent upon arising.

She had no desire to eat but there was no nausea or vomiting. Although she complained of borborygmus during her crampy episodes, there was no regurgitation or bloating.

Tests

Gina had an electrocardiogram taken in order to determine whether or not the disease had had any effect upon her heart. An earlier tracing revealed an infantile record. She had a sinus tachycardia rate of 100-157 per minute.

Stool specimens were collected for occult blood and other constituents. Gina was taught to collect them herself. When collecting stool for occult blood, the patient is usually deprived of meat and products for 24 hours. Iron preparations and vitamins which tend to make the stool dark brown or black, are eliminated during the test. In examining a stool specimen, if it floats on water, then excessive fat is present. Gastrointestinal hemorrhage or other defects of the tract can be detected through stool examination. The results obtained for Gina were considered to be within normal bounds.

X-rays of her elbows were taken from different angles. No abnormalities were noted. Similar films taken on a previous admission had revealed a bone structure for an age several years younger than herself with the epiphyses not yet fused. Poor fusion would have indicated a calcium deficiency.

A barium enema failed to reveal any particular abnormalities although the colon was seen to be unusually large. A gastrointestinal series carried out several days later showed that the descending portion of the duodenal loop was markedly irregular. The small bowel had a highly abnormal pattern with segmentation and flocculation of barium. The mucosa appeared swollen and irregular. The same test was repeated later, but this time a non-flocculating barium was used. Again, the mucosa of the small intestine appeared swollen, and the loops were moderately dilated.

Throughout Gina's hospital stay, blood chemistries were done. These included blood for serum carotene, total lipids, total protein. Vitamin A absorption studies were carried out since a defect in fat metabolism is very likely to result in an upset in its absorption and metabolism. The results were within normal limits, as they were for numerous other tests.

Nursing Care

Gina was admitted in no apparent distress and was not confined to bed. Her nursing care was really quite limited since she was capable of looking after herself and was not under any complicated treatment. Throughout her hospitalization she was on regular 24-hour urine collection which she was taught to save. All the diagnostic tests that she underwent were explained to her and she seemed to

understand the necessity for them very well. She was given an antispasmodic in the evenings for pain. This appeared to be quite effective.

When her gluten-free diet was discussed with Gina, she seemed to understand its principles, and to differentiate between the foods she was allowed to eat, and those forbidden.

She was discharged several weeks after admission with an excellent prognosis as long as she followed her diet very closely. An appointment was made for her to return to the clinic three weeks after discharge. I met Gina in the outpatient department on the day of her appointment and found that she was very happy and feeling well. She had gained 10-15 pounds and was back at work.

She found it rather depressing to be deprived of the foods she loved best. However she was trying to follow instructions and seemed to be progressing very well.

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A TROUBLED TEENAGER

MARY WILBY

In this story, the physical injury was only a symptom of hidden trouble.

THE TELEPHONE on the head nurse's desk rang briskly. The admitting officer's explanation to the student nurse who answered was equally brisk. "There's a new patient on the way. Ruptured bowel — she shot herself!"

As she helped to settle the new arrival comfortably into bed the student nurse noted with shocked surprise that the girl was just about her own age. Her pale pretty face, framed in soft red hair, wore a rather sulky, stubborn expression in spite of her pain. "Why did she ever do it?" the nurse thought "Surely it must have been an accident!"

The shooting had, in fact, occurred several days previously and by the patient's own admission, it was no accident. Dorothy had been admitted to the small local hospital for treatment. She had made very good progress until it was noted that normal bowel function seemed at a standstill. A corrective enema resulted in a sudden bowel perforation and the girl was hastily transferred to the nearest city for major abdominal surgery.

Miss Wilby is a 1960 graduate of Vancouver General Hospital.

Although the staff appreciated the emotional implications of the injury, their immediate attention had to be concentrated on repair of the physical damage. Perforation of the bowel with its accompanying shock and contamination of the abdominal cavity made immediate surgery a necessity. Her nurses and doctor guided Dorothy through the routine of x-ray examination, blood grouping, urinalysis and physical examination. As they worked with her, the staff tried to win the confidence of the girl. Each procedure was carefully explained and, in particular, both nurses and doctor tried to prepare her to accept the temporary colostomy that would be necessary. They tried to make her see why it was a necessity. They described what it would look like; how it would function; how function could be controlled; how Dorothy would be able to help herself. They emphasized its temporary nature.

Even a normal 16-year-old would have understandable difficulty in accepting the idea of a colostomy. Dorothy, in her highly confused emotional state, was never able to make an adequate adjustment.

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Her youth, her general good health and the usual postoperative measures of intravenous fluids, antibiotics, blood transfusions, good nursing care and medical supervision combined to make her recovery from surgery quick and uneventful from a physical standpoint. Gradually and patiently, her nurses learned enough about Dorothy's personal life to develop greater insight.

She volunteered little information about her parents excepting that her father was extremely quick-tempered. Her mother did not appear to have a very dominant role in family life. Dorothy had refused to attend school after reaching grade eight. She was then 16 years of age and it is possible that she felt self-conscious and ashamed to be so much older than her class-mates since the average age of the pupils was 13 years. Her refusal to continue her education precipitated a quarrel with her parents.

Dorothy's older brother had left school at the same age. Now, 19 years old, he had a reputation of being wild and unstable. A younger brother with symptoms of rheumatic heart disease received most of the mother's attention. In spite of her reticence concerning her parents, Dorothy obviously resented this. The remaining member of the family, 18-year-old Betty, was the only one who was well-adjusted. Fortunately, Betty had a boy friend whose family had given her the advice and friendly support that she needed. Betty was doing well in school and had a generally pleasant, happy disposition.

With increased understanding of the family background, her nurses began to see why Dorothy's emotional turmoil had eventually erupted into a deliberate act of violence. Since she could not get attention any other way, she would *make* people notice her! It was a more dramatic version of the small child's threat, "You'll be sorry when I'm dead!" Her great need for love and attention was exhibited in other ways. On several occasions during her hospitalization, the doctors judged her sufficiently recovered to complete her convalescence at home. Each time Dorothy suddenly developed nausea, vomiting and pain which, of course, delayed her discharge. The pain was always in an area well removed from the original site of operation. She refused to learn how to care for her colostomy adequately by herself. This attitude again was probably prompted by the fact that it would have deprived her of attention.

Dorothy's interests were very limited — reading and embroidery work being the only two leisure time activities for which she showed any enthusiasm. The occupational therapist and the nurses took the best advantage

possible of these two hobbies.

Since it was recognized that Dorothy needed trained help in solving her personal problems, her doctor arranged for psychiatric consultation. Dorothy developed a great deal of trust and confidence in the psychiatrist. She was able to discuss her worries much more freely with him than with any other staff member. Gradually she began to understand herself and her emotional responses.

The road to normal, well-adjusted adult life will not be an easy one for Dorothy. She will require continued counselling for some time to come. A social worker visited her home to determine whether or not the environment was suitable for convalescence. She attempted also to help the mother and father to gain a better understanding of this troubled, insecure daughter. The report of the visit indicated that the home conditions would be moderately satisfactory for Dorothy's convalescence.

The next step — and a very trying one — was to persuade Dorothy that she should go home. The colostomy was repugnant to her. It was very difficult to persuade her that she could or should take up her social activities again. She dreaded leaving the security of the hospital and the attention of the nurses. Over and over again the nurses emphasized the temporary nature of the colostomy. When, after much persuasion, she finally agreed to return home, her eventual return to hospital and closure of the colostomy were her chief goals. Apart from that the social worker and the nurses encouraged Dorothy to use this period of convalescence to plan for the future. They suggested that she should try to decide what type of career she might wish to follow and what she would need to do in preparation for it.

There are certain situations in our care of patients where it is of extreme importance to find out why the patient is ill or why he received an injury. The accident prone worker, the troubled teenager like Dorothy, the habitual absentee — we must seek far below the surface of the specific complaint to see where the trouble lies. It is not enough to treat the observable condition and ignore the emotional factors that are its cause.

Book Reviews

Persuasion by Herbert I. Abelson, Ph.D. 118 pages. The Ryerson Press, 299 Queen Street W., Toronto 2B. 1959. Price $4.25.
Reviewed by Miss Jean Dixon, chief psychologist, Provincial Guidance Clinic, Edmonton, Alta.

The purpose of this book is to present experimental evidence concerning the factors responsible for changing opinions and attitudes in modern society. This approach is advantageous in that it avoids personal biases, isolates various factors, and provides a uniform procedure for further experimentation. The reader must avoid broad generalizations from these findings since, under slightly different conditions, an experiment could have turned out differently. Some studies show inconsistent results; others vary with conditions not ordinarily under control of the persuader.

The author presents a series of questions or statements supplemented by specimen studies and a brief discussion. No special theme is developed. Some of the conclusions are:

It is often better to present more than one side of an argument. Under some conditions it is better to state conclusions.

The effect of an emotional or a rational appeal varies with the type of audience and the questions under discussion.

Mild threat may be more effective than strong threat.

A person's opinions and attitudes are strongly influenced by the groups to which he belongs and wants to belong.

Audience participation helps overcome resistance.

In time the effects of persuasive communication tend to wear off.

The level of intelligence of an audience determines the effectiveness of some kinds of appeal. The individual's personality traits affect his susceptibility to persuasion.

The motives attributed to a communicator may affect his success in influencing an audience. A communicator's effectiveness is increased if he expresses some views that are also held by his audience. The more extreme the opinion change that the communicator asks for, the more actual change he is likely to get.

The author concludes with a discussion of scientific methods used in social sciences and a few definitions. The material presented attests to the writer's belief that methods of persuasion are becoming increasingly effective but the audience is becoming increasingly sophisticated and skeptical. As a result people do not believe all that they hear and see in political propaganda and commercial advertising.

The book provides easy reading. We are given an introduction to one area of social science research. Unfortunately the summaries are so extremely brief that the reader has too little information with which to evaluate individual studies. He must take the author's conclusions at face value. If the reader is sufficiently interested, however, he can refer to the bibliography.

The practical value of this text to nurses is questionable. The young public health nurse, who is concerned about educational programs does not have the background of experience necessary to utilize the ideas presented. The inexperienced would be tempted to make a list of rules that would vary in effectiveness. The experienced nurse-persuader might find it interesting to pick up new ideas or to check her own against the experimental findings. The individual who has a special interest in the techniques of persuasion stands to gain most.

The Child in Hospital by Hedley G. Dimock. 236 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 1959. Price $3.75.
Reviewed by Miss Iris Ramsay, pediatric supervisor, Royal Inland Hospital, Kamloops, B.C.

This text covers every phase of the emotional, social and recreational needs of children in hospital. Case histories are presented to point out the effect of hospital experience on different children. There is a discussion of the child as a person emphasizing the factors that influence him, and showing how his basic emotional needs are met. The importance of family relationships and the attitude of the family to illness and hospitalization is indicated.

The advantages and disadvantages of "rooming-in" are fully discussed.

The chapter on suggested social educational and recreational programs for young patients should prove very helpful. The importance of congenial interpersonal relationships among the hospital staff and the need

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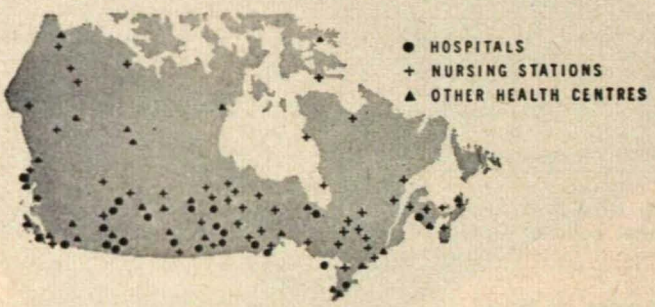

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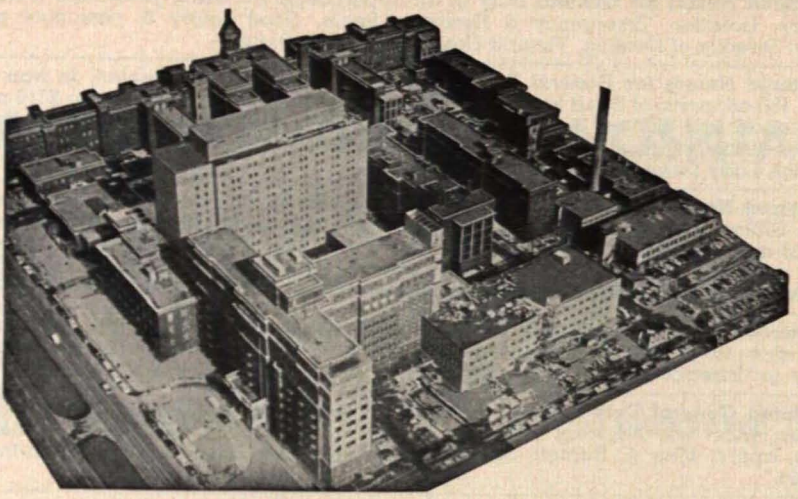

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Nurses required Miller Bay Indian Hospital, Prince Rupert, B.C. Accommodation available, good fringe benefits, salary up to $3,930. Apply to: Regional Nursing Supervisor, 4824 Fraser Street, Vancouver, British Columbia.

THE
VANCOUVER GENERAL HOSPITAL

Appointments to nursing positions are available.

Good personnel policies in effect including medical welfare plan,
40 hour week — four weeks' vacation.

Salary $297 - $359 per month
with consideration for experience or special preparation.

Please apply to:

PERSONNEL DEPARTMENT,
10TH AVENUE AND WILLOW STREET,
VANCOUVER 9, BRITISH COLUMBIA.

THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Duty Staff Nurses for 80-bed hospital, 20-mi. from London. Accommodation available in residence, excellent personnel policies. Apply to: Administrator, Strathroy General Hospital, Strathroy, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

P.E.I.

Director of Nursing Education, degree preferred, **Medical-Surgical Clinical Instructor, Nursing Arts Instructor,** for school associated with 200-bed hospital, salary based on qualifications & experience. Apply to: Director of Nursing, Prince Edward Island Hospital, Charlottetown, Prince Edward Island.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Clinical Instructor in Rehabilitation Nursing and Rehabilitation Nurse for expanding program in a New England rehabilitation facility. Full details upon request. Write Box N, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $275 per mo. 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

SASKATCHEWAN

Registered Nurses for General Duty for 24-bed hospital, a new 34-bed hospital presently under construction. Present hospital to be converted to a nursing home for the aged. Salary schedule $290-$350 gross, $10 increments every 6-mo. Living accommodation available in new residence. T.V. set, board & lodging $34.50 per mo., 3-wk. vacation after 1 year service. 8 statutory holidays, 1½ days sick leave accumulative up to 90-days, 40-hr. wk., bus service daily to major city. Apply to: Secretary-Manager, Union Hospital, Leader, Saskatchewan.

Graduate or Registered Nurses (2) for 16-bed Elrose Union Hospital, salary per S.R.N.A. Full maintenance $34.50 per mo., 40-hr. wk., 1-mo. vacation after 1-yr. & statutory holidays. Apply giving phone number, age & marital status to: J. V. Nouch, Secretary-Manager, Union Hospital, Phone 63, Elrose, Saskatchewan.

U.S.A.

Operating Room Supervisor for 238-bed JCAH approved hospital. Intern, Resident & Nursing Education programs. Candidates with BS degree preferred. Apply to: Mrs. Virginia Krahl, Director of Nursing Service, Cottage Hospital, 320 West Pueblo Street, Santa Barbara, California.

Registered, General Duty & Operating Room Nurses for modern 74-bed District Hospital, midway between San Francisco & Los Angeles, California. Starting salary $350 per mo., 40-hr. wk., living quarters available. Contact: Administrator, District Hospital, 869 Cherry Avenue, Tulare, California.

Registered Nurses excellent opportunities. Progressive 440-bed General Hospital, expanding to 525-beds in early 1961. Expansion is creating openings in all areas. Salary range $370 - $400 per mo., $25 P.M. & night differential. $25 additional for surgery. Liberal vacation plan, 7 paid holidays, 40 hr. wk. health insurance & retirement plan. Close to all summer & winter, mountain & ocean activities. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

SOUTHWEST REGIONAL HOSPITAL COUNCIL

REGIONAL NURSING COUNSELLOR

Applications are invited for the above position.

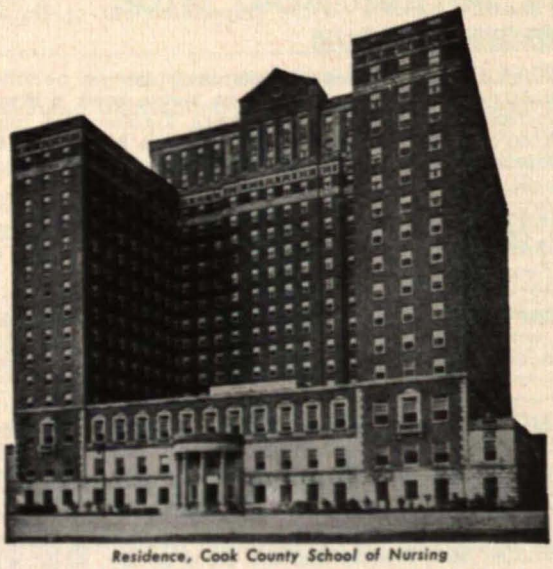
Requirements: Reg. N. with courses in nursing administration and considerable professional supervisory experience. Duties include assistance and advice to a group of 20 small hospitals located in S.W. Saskatchewan.

Salary in the scale $379 - $461 per month.

Mileage and subsistence allowances. Good personnel policies, including superannuation and group life insurance benefits.

Detailed applications to:

REGIONAL HOSPITAL CO-ORDINATOR,
SOUTHWEST REGIONAL HOSPITAL COUNCIL,
162 - 1st AVENUE N.W.,
SWIFT CURRENT, SASKATCHEWAN.



Residence, Cook County School of Nursing

NURSES WHO LIVE HERE NEVER STOP LEARNING . . . GROWING

. . . THEY WORK AT

COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers of the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385* for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff & Supervisory permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $335 - $395, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses for General Duty in modern, accredited 76-bed hospital — South Central California near Sequoia National Park. Good salary & benefits. Excellent working conditions. Ideal community. Winter & Summer recreation Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, 215 Crespi Avenue, Exeter, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

General Duty Nurses — J.C.A.H. accredited 99-bed hospital midway between Los Angeles & San Francisco. Salary depends upon experience & qualifications. Rooms available in modern nurses' residence $10 per mo., 40-hr. wk., 15 days vacation, liberal sick leave, 12 holidays. Social Security benefits. Write: Superintendent of Nurses, General Hospital, Tulare, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro, area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $350 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Good salary, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

REGISTERED NURSES
NURSING ASSISTANTS

Required for all departments in new 160-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan, 40-hour week.

Apply stating age, qualifications to:

DIRECTOR OF NURSING,
OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL, OAKVILLE, ONTARIO

CITY OF BELLEVILLE — HEALTH DEPARTMENT

SUPERVISOR *required for Generalized Program*

Blue Cross 50% paid by City — Pension, Group Insurance and cumulative sick leave available. Four (4) weeks vacation.

Car provided if required or car allowance.

Salary — $4,500 - $5,500 — depending upon qualifications and experience, annual increments.

Apply to:

MEDICAL OFFICER OF HEALTH,
266 PINNACLE STREET, BELLEVILLE, ONTARIO.

NOTRE DAME HOSPITAL OF MONTREAL
NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 10 days; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year, Pension plan.
Opportunities for promotion — Inservice education program.

For further information, write to:

LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

DIRECTOR OF NURSING

Expanding 113 bed hospital, located in an attractive community one hour from downtown Toronto, requires a Director of Nursing to participate in the planning and organizing of an increase to 250 beds. Salary open.

APPLY:

ADMINISTRATOR, YORK COUNTY HOSPITAL, NEWMARKET, ONTARIO.

PUBLIC HEALTH NURSES

Applications are invited from Graduate Nurses holding a Diploma in Public Health Nursing or equivalent, for positions in Nova Scotia.
Salary $3,150 to $4,200, depending upon experience; uniforms are provided; cars are provided or mileage paid; Civil Service and Superannuation benefits.

For further information and Application Forms, Apply to:
DIRECTOR, DIVISION OF PUBLIC HEALTH NURSING,
DEPARTMENT OF PUBLIC HEALTH, BOX 488, HALIFAX, NOVA SCOTIA.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi. from Boston. Living quarters available. Minimum starting pay $70 R.N.'s., L.P.N's. $58 per wk. Experience considered, differentials for reliefs, nights. Contact: Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state — General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Staff Nurses for 157-bed General Hospital with school of nursing, expansion program underway for 300-beds. Full maintenance available. One-half paid tuition at university of choice after one year of employment; excellent personnel policies. 10-min. from center city - Philadelphia, all shifts available. Apply: Director of Nursing, The Woman's Hospital of Philadelphia, Philadelphia 4, Pennsylvania.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Supervisors — Medical-Surgical, Pediatrics, Obstetrics & Psychiatric. Base salary $400 to $439, depending upon preparation & experience. Liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs. Housing available on campus or in vicinity of hospitals. Apply: Director Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Staff Nurses: Are you interested in working in a fully accredited 71-bed hospital with high standards of patient care? For complete information write to: Director of Nursing, Gifford Memorial Hospital, Randolph, Vermont.

GRADUATE NURSES

and

Certified Nursing Assistants

required for

FIVE SUMMER CAMPS

STRATEGICALLY LOCATED
THROUGHOUT ONTARIO
AND NEAR:
OTTAWA - LONDON
COLLINGWOOD
PORT COLBORNE
KIRKLAND LAKE

Apply in writing to:

Miss Helen Wallace, Reg'd N.
SUPERVISOR OF CAMPS
ONTARIO SOCIETY FOR
CRIPPLED CHILDREN
92 COLLEGE STREET
TORONTO, ONTARIO

BURLINGTON, ONTARIO

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

are needed for

a new 225 bed hospital

to be opened

February 1961

For information, write to:

DIRECTOR OF NURSING
JOSEPH BRANT MEMORIAL HOSPITAL
1240 NORTH SHORE BLVD.,
BURLINGTON, ONTARIO

GUELPH GENERAL HOSPITAL

Active — 200 beds — Fully Accredited

Requires

GENERAL STAFF NURSES

Pleasant city of 38,000 close to larger centers

Excellent salary and personnel policies

For further details apply to:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
GUELPH, ONTARIO.

McKELLAR GENERAL HOSPITAL

School of Nursing

will have openings for

INSTRUCTORS

in Medicine, Surgery and Pediatrics

by July 15th, 1961

Qualified applicants are invited to apply:

Salary commensurate with experience and qualifications.

Apply to:

DIRECTOR,
McKELLAR GENERAL HOSPITAL,
FORT WILLIAM, ONTARIO.

ADVISER TO SCHOOLS OF NURSING

The Saskatchewan Registered Nurses' Association
invites applications for the position of

ADVISER TO SCHOOLS OF NURSING

Applicants must possess a degree in nursing and have a minimum of five years experience in nursing education and nursing service of which the major portion has been in nursing education.

Apply in writing stating qualifications, experience and salary expected to:

MISS LOUISE MINER,
PRESIDENT, S.R.N.A.
5 BARTLEMAN APT.,
REGINA, SASKATCHEWAN.

A job description is available

KINGSTON GENERAL HOSPITAL

requires

GENERAL DUTY NURSES

for:

Medical, Psychiatric, Surgical Floors and Intensive Care Unit
(male or female Registered Nurses considered for all above positions)

Certified Nursing Assistants

Trained psychiatric attendants (F)

For full details relating to hours, vacations and benefits, apply to:

DIRECTOR OF NURSING,
KINGSTON GENERAL HOSPITAL,
KINGSTON, ONTARIO

HEALTH EDUCATION BURSARY

REQUIREMENTS

1. Baccalaureate degree with preparation in public health and education. Education courses may be supplemented at summer school prior to fall admissions. Must have high scholastic standing to meet the admission requirements of the University of Michigan or California.
2. At least 3 years professional experience.
3. Three letters of recommendation. We are only interested in true leaders.
4. A personal interview must be arranged by you at the OTA office.
5. At least 2 years service with the OTA following the course. Must be free to travel throughout the province and to locate in a specified region in order to develop the health education program.

Amount:

Bursary $3,600; Salary $4,800 minimum plus expenses.

Apply:

MISS FLORIS E. KING, B.Sc.N., M.P.H.,
HEALTH EDUCATION CONSULTANT,
ONTARIO TUBERCULOSIS ASSOCIATION,
3050 YONGE ST., TORONTO 12, ONT.

VICTORIA HOSPITAL
LONDON, ONTARIO

Modern 900-bed hospital

requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

Apply:

DIRECTOR OF NURSING
VICTORIA HOSPITAL
LONDON, ONTARIO.

SUPERINTENDENT OF NURSES

FOR

CLEARWATER LAKE HOSPITAL

THE PAS, MANITOBA

Well equipped 160-bed hospital with general and tuberculosis patients. Salary range $355-$400 per month, commensurate with experience and qualifications. Good residence accommodation and excellent personnel policies.

For information and application apply:

DIRECTOR OF NURSING SERVICES,
SANATORIUM BOARD OF MANITOBA,
1654 PORTAGE AVENUE, WINNIPEG, MANITOBA.

EDUCATIONAL DIRECTOR

FOR NEW SCHOOL OF NURSING

New school building, new student residence. Hospital opened in 1956, all services; 250-beds.

Present plan to enrol first class of students for September 1961. Director required at once to facilitate planning an educational program and arranging for staff.

Opportunities for additional education at Laurentian University.

Salary according to qualifications and experience.

Apply:

DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,
REGENT STREET SOUTH, SUDBURY, ONTARIO.

THE SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL

REQUIRES

INSTRUCTOR IN PEDIATRIC NURSING

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of two years of nursing education followed by one year internship. One class of 30 students is admitted yearly. Duties include clinical and classroom instruction.

Requirements: University preparation in Nursing Education
Salary differential for degree.

For further information apply to:

DIRECTOR, SCHOOL OF NURSING, 2240 KILDARE RD., WINDSOR, ONT.

GENERAL DUTY NURSES (2)

FOR A MODERN, NEW 25-BED HOSPITAL

3 doctors on staff. 9 Registered Nurses, 3 Nursing Assistants, 1 Laboratory Technician, 1 X-Ray Technician. 5 day 40-hour week. No split shifts, 3 weeks vacation after one year service, 9 statutory holidays. Salary $280-$380. Single rooms in modern nurses' residence with television. Board and room $1.15 per day, laundry free. Established personnel policies. Apply in writing to:

JANIE SUTHERLAND, SUPERINTENDENT OF NURSES,
UNION HOSPITAL, P.O. BOX 760, ESTON, SASKATCHEWAN.

KINGSTON GENERAL HOSPITAL

invites applications for position of

DIRECTOR OF NURSING

The hospital is situated in the cultural and historic city of Kingston. The new Connell Wing recently opened increased bed capacity to 625. A modern, new cafeteria, with a nurses' training school completes a brief picture of this fully accredited General Hospital. Salary is dependent upon qualifications and experience. Excellent personnel policies with 4 weeks annual vacation, pension and medical plans.

For further information address inquiries to:

SUPERINTENDENT
KINGSTON GENERAL HOSPITAL
KINGSTON, ONTARIO

VICTORIAN ORDER OF NURSES FOR CANADA . . .

requires

PUBLIC HEALTH NURSES

for Staff and Supervisory positions in various parts of Canada.

Applications will be considered from Registered Nurses without Public Health training but with University entrance qualifications.

SALARY, STATUS AND PROMOTIONS ARE DETERMINED IN RELATION TO THE QUALIFICATIONS OF THE APPLICANT.

Apply to:

Director in Chief,
Victorian Order of Nurses for Canada
5 BLACKBURN AVENUE
Ottawa 2, Ont.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS' HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.
SHAUGHNESSY HOSPITAL, VANCOUVER, B.C.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence—for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg.
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

GENERAL DUTY NURSES

required by

The Dauphin General Hospital Ultra-modern 100 bed hospital in process of construction located in the beautiful Riding Mountain Resort area of Manitoba. 40 hour week, excellent personnel policies. Residence facilities, minimum starting salary $280 per month, assistance with transportation given if necessary.

Apply to: Superintendent of Nurses

DAUPHIN GENERAL HOSPITAL
DAUPHIN, MANITOBA

PROVINCE OF ALBERTA

EMPLOYMENT OPPORTUNITY

GENERAL DUTY NURSES

Salary - $3,480. to $4,080. per annum. 40-hour week, Civil Service holiday, sick leave and pension programs.

DEPARTMENT OF PUBLIC HEALTH
Baker Memorial Sanatorium
Calgary, Alberta

Apply, giving full details, to the Baker Memorial Sanatorium, Calgary, Alberta.

THE CENTRAL REGISTRY OF GRADUATE NURSES TORONTO

Furnish Nurses
• at any hour •
DAY or NIGHT

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427 Avenue Road, TORONTO 7

JEAN C. BROWN, REG. N.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies.
APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL & OBSTETRICAL } DEPARTMENTS

Apply

EDITH G. YOUNG, REG.N.,
ASSISTANT ADMINISTRATOR - NURSING

SOUTH WATERLOO MEMORIAL HOSPITAL GALT

Invites application for the following positions

1. Instructor for Classroom Teaching
2. General Duty Nurses for Operating Room, Surgical and Medical Unit.

For further information write:

THE DIRECTOR OF NURSING
GALT, ONTARIO or PHONE 621-2330

GENERAL DUTY NURSES

WANTED

Salary — $265 - $315 per month 40-hour week, no split shifts.

Vacation — 3 weeks after one year; statutory holidays — eight (8); sick leave — cumulative from date of employment.

Transportation — advanced on repayable basis For 75-bed fully accreditated hospital built in 1956, located in south-western Ontario.

Apply to: Director of Nursing,

SYDENHAM DISTRICT HOSPITAL
WALLACEBURG, ONTARIO

THE GENERAL HOSPITAL OF PORT ARTHUR

Invites applications from

Registered Nurses for General Staff positions.

Excellent personnel policies.

For further information write:

THE DIRECTOR OF NURSING
THE GENERAL HOSPITAL OF PORT ARTHUR
PORT ARTHUR, ONTARIO.

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH
B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY $346-$405 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, write to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION NO. 60:484.

Official Directory

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74 Stanley Avenue, Ottawa

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Past President	Miss Alice Girard, Hôpital St. Luc, Lagauchetière St., Montreal, Que.
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Quebec	Rev. Sister Florence Keegan, Institut Marguerite d'Youville, Montreal.
Ontario	Rev. Sister Madeleine of Jesus, Ottawa General Hospital, Ottawa.
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